

**ALLISON LINQUIST, MD PC
REGISTRATION FORM**

(Please bring registration, review of systems, medical history, referral, insurance card, and co-payment to appointment.)

Today's Date:			
PATIENT INFORMATION			
Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>
Street address:	Social Security no:	Date of birth:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
P.O. Box:	City:	State:	ZIP Code:
Home phone no:	Work phone no:	Cell phone no:	
Occupation:	Employer and address:	Employer phone no:	
E-mail address:	I do not have e-mail: <input type="checkbox"/>	May we send you an e-mail appointment reminder? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Care Physician:	Primary Care phone no:	Did your doctor give you an insurance referral for our office? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Other family members seen here:			

INSURANCE INFORMATION			
Person responsible for bill:	Birth date:	Address (if different):	Home phone no:
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Occupation:	Employer and address:	Employer phone no:	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
PRIMARY INSURANCE:			
Subscriber's name:	Subscriber's S.S. no:	Birth date:	Group no: Policy no: Co-pay:
Patient's relationship to subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
SECONDARY INSURANCE (if applicable)		Subscriber's name:	Group no: Policy no:
Patient's relationship to subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
FOR CHILDREN ONLY:			
Father's Full Name:		Mother's Full Name:	
Father's Home Phone:	Father's Work Phone:	Mother's Home Phone:	Mother's Work Phone:

PHARMACY INFORMATION	
Pharmacy name:	Pharmacy phone number:
Pharmacy address:	

The above information is true to the best of my knowledge. I authorized my insurance benefits be paid directly to Allison Linquist, MD PC. I understand that I am financially responsible for any balance. I also authorize Allison Linquist, MD PC or insurance company to release any information required to process my claims. A charge may be incurred for a no show &/or cancellation without required notice.

Patient / Guardian signature

Date