ALLISON LINQUIST, MD, PC

REGISTRATION FORM

Please bring registration, referral, insurance card, and co-payment to appointment.

PATIENT INFORMATION

Last Name:	First:	Middle:	☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.	Marital status (circle one): Single Mar Div Sep Wid
Street address:		Social Security no:	Date of birth:	Sex: M ☐ F ☐
P.O. Box:	City:		State:	ZIP Code:
Home phone no:	Work phone no:	Cell phone no:		Preferred Contact no. ☐ Home ☐ Cell
Occupation:	Employer and address:		Employer phone no:	
E-mail address:			May we send you an e-mail appointment reminder? ☐ Yes ☐ No	
Primary Care Physician:		Primary Care phone no:	Did your doctor give you an insurance referral for our office? Yes ☐ No ☐	
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?			☐ Yes ☐ No		
Occupation:	Employer and address:			Employer phone no:	
Is this patient covered by insurance?			☐ Yes ☐ No		
PRIMARY INSURANCE:		INSURANCE ADDRESS:			
Subscriber's name:	Subscriber's S.S. no:	Birth date:	Group no:	Policy no:	Co-pay:
Patient's relationship to subscriber:		Self ☐	Spouse ☐	Child ☐	Other ☐
SECONDARY INSURANCE & ADDRESS:		Subscriber's name:		Group no:	Policy no:
Patient's relationship to subscriber:		Self ☐	Spouse ☐	Child ☐	Other ☐
FOR CHILDREN ONLY:					
Father's Full Name:		Mother's Full Name:			
Father's Home & Mobile Phone:	Father's Work Phone:	Mother's Home & Mobile Phone:		Mother's Work Phone:	

PHARMACY INFORMATION

Pharmacy name:	Pharmacy phone number:
Pharmacy address:	

I certify that the above information is correct and I authorize my insurance benefits be paid directly to Allison Linquist, MD PC. I understand that payment is my responsibility regardless of insurance coverage. 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. I certify that I have read and understand the HIPPA Notice of Privacy Policies.

Patient / Guardian signature ______________________ Date ______________