

**STEPHEN T. LINN MD LLC**  
**(Please Print)**

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ PATIENT'S NAME: \_\_\_\_\_  
Last Name, First Name Middle Initial

PERMANENT ADDRESS: \_\_\_\_\_ APT # \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

LOCAL ADDRESS: \_\_\_\_\_ APT # \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SEX: ( M / F ) MARITAL STATUS : ( S / M / W / D )  
Month day year

Phone #:( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone #:( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Other Phone #:( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PCP Phone:( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Last Name First Name

PATIENT EMPLOYER: \_\_\_\_\_

**Primary Insurance**

**Secondary Insurance**

Ins. Co. Name: \_\_\_\_\_

Ins. Co. Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ M / F

Insured's Date of Birth: \_\_\_\_\_ M / F

Insured's Employer: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insured's SS# \_\_\_\_\_

Insured's SS# \_\_\_\_\_

**Who may receive information regarding your Protected Health Information? (Check all that apply)**

Spouse \_\_\_\_\_ Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Children \_\_\_\_\_ Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Significant Other/Friend: \_\_\_\_\_ Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

May we leave messages regarding test results and appointments on your answering machine? \_\_\_\_\_ Yes \_\_\_\_\_ No

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

Date: \_\_\_\_\_ Signature \_\_\_\_\_  
Circle One (PATIENT/ PARENT /GUARDIAN)

IF YOU HAVE TWO INSURANCE COMPANIES, PLEASE PRESENT BOTH CARDS SO THAT WE MAY FILE WITH YOUR SECONDARY CARRIER FOR ANY BENEFITS DUE YOU.