

Boulder Endocrinology, PLLC
892 West South Boulder Road
Louisville, Colorado 80027

PATIENT REGISTRATION

Patient Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email address _____ Fax _____

SS# _____ Date of Birth _____ Sex: female, male

Marital Status _____ Spouse/partner name (if any) _____

Employer Name _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

Which is preferred phone number to call? Home, Work, Cell.

Is it okay to leave voice mail messages with private health information? Yes, No

Please list any family members with whom we can discuss your medical care: None, list: _____

How would you prefer to receive lab results or notice of other reports? Fax, Email, Standard Mail

INSURANCE INFORMATION

Primary Insurance

Insurance Name _____ Policy # _____ Phone _____

Name of Insured _____ Relationship _____

SS# _____ Date of Birth _____

Employer Name _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

Secondary Insurance

Insurance Name _____ Policy # _____ Phone _____

Name of Insured _____ Relationship _____

SS# _____ Date of Birth _____

Employer Name _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

Referring Physician Name _____ Phone _____

PCP Name _____ Phone _____

Emergency Contact _____ Phone _____

I hereby authorize Dr. _____ and providers of Boulder Endocrinology, PLLC, to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency. Initial _____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and understand I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. Initial _____

I acknowledge receipt of the Notice of Privacy Practices for Boulder Endocrinology, PLLC Initial _____

Signature of Patient / Authorized Person _____ Date _____