

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 _____
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
How would you like 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 the 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.

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.

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

Signature of Patient / Authorized Person _____ Date _____