Denver East: 3894 Olive St. 80207 303.320.8352
Lafayette: 1285 Centaur Village Dr. 80026 303.665.2341
Englewood, Bella 180 E Hampden #100 80113 303.789.4968

REGISTRATION

Last Name_____First Name_____Middle Initial _____

Address_____City_____State_____Zip_____

Home Phone_____Work Phone_____Cell Phone _____

SS#_____Date of Birth_____Sex_____Marital Status_____

Employers Name_____Phone_____

Employer Address_____City_____State Zip_____

INSURANCE INFORMATION

Primary Insurance

Insurance Name_____Policy #_____Phone_____

Name of Insured_____Relationship_____

SS#_____Date of Birth _____

Employers Name_____Phone_____

Employer Address_____City_____State_____Zip_____

Secondary Insurance

Insurance Name_____Policy #_____Phone_____

Name of Insured_____Relationship_____

SS#_____Date of Birth _____

Employers Name_____Phone_____

Employer Address_____City_____State_____Zip_____

Referring Physician Name_____Phone_____

Primary Care Physician Name_____Phone_____

Emergency Contact_____Phone_____

Preferred Pharmacy_____City_____Phone_____

I hereby authorize providers of Marisol Health 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.

Signature of Patient / Authorized Person_____Date_____

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

Signature of Patient / Authorized Person_____Date_____