



Colorado Cardiovascular Center
3000 Center Green Drive, Suite 120
Boulder, CO 80301
Jamie J. Doucet, M.D.

FULL NAME: _____
Last first middle

ADDRESS: _____

CITY/STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____

DATE OF BIRTH _____ SOC SEC # _____

PATIENTS EMPLOYER: _____ Ph: _____

PRIMARY CARE PHYSICIAN: _____ Ph: _____

EMERGENCY CONTACT: _____ Ph: _____

EMERGENCY CONTACT: _____ Ph: _____

INSURANCE COMPANY _____

POLICY HOLDER _____ DOB _____

I give permission for CCC, LLC, to release any medical records that my insurance company requests and permission for all insurance payments to be made to my provider at Colorado Cardiovascular Center, LLC.
Tax ID 84-1521418.

ALL PATIENTS: I AM AWARE THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED ON THE DATE OF SERVICE.

HMO, POS AND MANAGED CARE PATIENTS:

If we have not yet received the authorization, we will see you, but you may be responsible for the charges incurred today.

signature

date