BRIAN J. MARIEN, MD, LLC
REGISTRATION FORM

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Employer:_____

DOB:_____ SS#:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ email:_____

Sex: M F

Primary Care Physician:_____

Person to be Contacted for Emergency:_____

Phone of Emergency Contact:_____
(PLEASE INCLUDE ON HIPAA FORM)

Primary Insurance:_____

Secondary Insurance:_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the aforementioned company/ies. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the physician to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions:

Patient/ Guardian:_____ Date:_____