

COHEN MEDICAL ASSOCIATES

(PLEASE PRINT)

Name: _____ Social Sec #: _____
Last Name First Name Initial

Address: _____
Number and Street Apt # City State Zip Code

Ph Number: () _____ - _____ Alternate Ph: () _____ - _____ Cell #: () _____ - _____

Email Address _____ @ _____ Referred by: _____

Alternate Address: _____

Date at Alternate Address: From _____ To _____

Sex: ___ Male ___ Female Age: _____ Birthdate: _____ Married ___ Divorced ___
Single ___ Widowed ___

Patient employed by: _____ Occupation: _____

Primary Insurance: _____ Policy Number: _____ Copay \$ _____

Policy Holder: ___ Self ___ Spouse ___ Parent ___ Guardian

Policy Holder Name (if other than self) _____ Birthdate: _____

Secondary Insurance: _____ Policy Number: _____ Copay \$ _____

Policy Holder: ___ Self ___ Spouse ___ Parent ___ Guardian

Policy Holder Name (if other than self) _____ Birthdate: _____

Race: ___ American Indian or Alaska Native ___ Asian ___ Black or African American
___ Native Hawaiian or other Pacific ___ Refuse to report/Unreported ___ White
Ethnicity: ___ Hispanic or Latino ___ Non-Hispanic or Latino ___ Refuse to Report/Unreported
Primary Language: English French German Japanese Mandarin Russian Spanish

Patient's or authorized person's signature: I authorize the release of any medical information necessary to process this claim and also certify that the above information is correct. I authorize payment of medical benefits to Cohen Medical Associates, Dr Robert Cohen/Dr Douglas Colman/Dr Lee Greene/Dr Jo Ann Yi and I hereby agree to pay any excesses not covered by insurance or in the event of no insurance. It is understood and agreed by the undersigned patient/representative that payment of all billing statements for services rendered by Drs Cohen/Colman/Greene/Yi is due upon receipt. Further, in the event that litigation is commenced to collect any amount(s) owed to Dr Cohen/Dr Colman/Dr Greene/Dr Yi, the undersigned patient/representative agrees to pay the costs and expenses of such litigation, including Dr Cohen's/Dr Colman's/Dr Greene's/Dr Yi's reasonable attorney's fees. Please note that there is an additional fee for all returned checks and patient balances over 30 days

Signature

Date

Acknowledgement of Privacy

I hereby acknowledge that I have read the Notice of Privacy Practices

Signature: _____ Print Name: _____ Date: _____

Patient Contact Information

All calls regarding your care, test results and appointments will be made to your home phone number. If you would like us to contact you at an alternate phone number, please indicate the number: () _____

Please check one of the following below:

___ I hereby authorize contact to me by telephone and if I am not present, you may leave a message on my answering machine or with whomever answers the phone.

___ I prefer that the office **NOT** speak to anyone other than myself.