BRIAN D. COHEN, M.D., P.L.L.C.

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NEW YORK, NY 10065
212-472-4700

PATIENT INFORMATION FORM

Name: ________________________________ **Age**: ______ **DOB**: ______/______/______
Sex: M/F **Marital Status**: S/M/W/D **Spouse's Name**: ________________________________

Home Address: ____
Street City State Zip Code
Home #: ________________________________ **Work #**: ________________________________
Cell #: ________________________________ **Email**: ________________________________
Social Security #: ______________-_________-________________
Driver's License State & #: ________________________________

Occupation: ________________________________
Employer: ________________________________
Work Address:____
Street City State Zip Code
Person to contact in case of an emergency:
Name: ________________________________ Telephone #: ________________________________

Person Financially Responsible:
Patient Parent/Guardian Other ________________
If Parent or Other, please complete the following:
Name: ________________________________
Relationship: ________________________________
Address: ________________________________
____
Telephone number: ________________________________

INSURANCE Information (if applicable):
Primary Insurance: ________________________________
Relationship to Subscriber: ________________________________
Policy #: ________________________________
Group #: ________________________________
If subscriber is other than patient:
Subscriber Social Security #: ____________________
Subscriber DOB: ____________________________

Referred By: ________________________________

Primary Care Physician:
Name: ____
Address: ____
Telephone #: ________________________

I, the undersigned, herby consent to care and treatment now and in the future. In the event that my insurance company is billed, I authorize payment of medical benefits to the physician(s) or supplier of rendered services. If my insurance company is not billed or if my insurance company fails to pay for services or does not pay a claim in full, I understand that I am responsible for payment of charges for services rendered. I authorize the release of any medical information necessary to process my insurance claim.

Patient's Signature: ____

Parent or Guardian's Signature: ____
Relationship

Date: ______________