MARK W. COHEN, PH.D.
126 WELLINGTON PLACE
CINCINNATI, OHIO 45219

PHONE (513) 651-5605

PATIENT CONTACT INFORMATION

Please respond thoroughly to all of the following questions, taking care to print clearly.

Patient

Name: _____

Street address: _____ Apt.: _____

City: _____ State/Province: _____ Zip/Postal code: _____

Phone: *(Home)* _____ *(Work)* _____

Date of birth: _____ Social security/ID number: _____

Contact Information

How may we contact you regarding appointments, treatment or other pertinent patient care information?

Home phone: _____ ☐ Yes ☐ No

Work phone: _____ ☐ Yes ☐ No

Cell phone: _____ ☐ Yes ☐ No

May we leave a voice mail or an answering machine message?

Mail: _____

E–mail: _____

Please list any restrictions regarding messages or reminders:

_____

_____

_____

I authorize the following person(s) listed below to receive information about appointments:

_____

_____

_____

In case of emergency, I authorize the following persons, as deemed appropriate, to receive notification:

Personal contact:

Name: _____ Phone: _____

Relationship to patient: _____

Family physician:

Name: _____ Phone: _____

Street address: _____ Suite: _____

City: _____ State/Province: _____ Zip/Postal code: _____

I, _____, hereby authorize contact with these parties, as specified above.

_____ _____

Signature of patient or authorized person *Date*

Health Insurance *(if applicable)*

If you intend to submit a claim to your health insurance company, please provide the information requested below and sign and date the release of information authorization that follows:

Insurance Company

Name of company: _____

Policy name: _____ Phone *(if any)*: _____

Street address: _____ Suite: _____

City: _____ State/Province: _____ Zip/Postal code: _____

Subscriber (Policy Holder)

Name: _____

Street address: _____ Apt.: _____

City: _____ State/Province: _____ Zip/Postal code: _____

Phone: *(Home)* _____ *(Work)* _____

Date of birth: _____ Social security/ID number: _____

Place of employment: _____

Group identification number: _____

Individual/Personal identification number: _____

I, _____, hereby authorize the release of information to process insurance claims and approve having insurance payments sent directly to this office.

_____ _____

Signature of patient or authorized person *Date*