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## 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  
Mail: \_\_\_\_\_  
E-mail: \_\_\_\_\_

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

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*