

(Please PRINT clearly and complete all blanks.)



Randall Cohen MD

Patient Information

Name _____ Date of Birth _____ Male ___ Female ___

Address _____ City/State _____ Zip code _____

Telephone _____ Social Security# _____ Marital Status: S M W D

Employer _____ Employer Address _____

Work Phone _____ Cell Phone/Other _____

Spouse/Significant Other _____

Primary Care Physician _____ Referred By _____

Insurance Information

Name of Insurance Company _____

Insurance address _____

ID# _____ Group# _____ Copay Amount _____

Insured's Name _____ Relationship to Patient _____

Social Security Number _____ Date of Birth _____

Insured's Address _____ Zip Code _____

Insured's Employer _____ Work Telephone _____

Employer's Address _____

Emergency Contact

Name _____ Relationship _____

Telephone _____ Work Telephone _____

Statement of Insurance Assignment

I hereby assign, transfer and set over to Catalina Ear Nose and Throat PC all my rights, titles and interests to my medical reimbursement benefits under insurance policies. I am financially responsible for the charges incurred apart from those contracted through my insurance company, including the balance remaining after payment of possible insurance benefits. Should my account be delinquent and referred for collection I will be held responsible for all costs of collections, attorney's fees, and court costs resulting from such actions. I permit a copy of this authorization to be used in the place of the original. My signature below shall be valid for the course of my treatment.

Release of Medical Records

I authorize release of medical records and/or studies to Catalina Ear Nose & Throat PC from any source for evaluation and care. I also authorize release of medical information necessary to process my claims.

Signature _____ Date _____