Dr. Stephen Cohen, O.D., P.C.

We are committed to providing you with the highest level of personalized care and we welcome you to our family of patients!

To complete this form you can:

- Print the form, fill it out and Fax it back to us at: **480.367.6711**
- Bring the completed form to your appointment.

Name:

____

(Last) (First) (M.I.) (Nickname)

Gender: M F ***DOB:***_________ ***SS#*** ____________ ***Marital Status:*** M S D W

Address:

____

(Street Address)

____

(City) (State) (Zip Code)

Phone(s):

____

(Home) (Work) (Cell) (Fax)

E-Mail: ____

Occupation: ______________________ ***Employer:*** ____________________

Names/Ages of Children living at home: ______________________________

If Student: Grade: ____________________ School: ____________________

Date of Last Eye Exam: _________________ ***Name/City of Dr.*** _________________

Person responsible for account ____________________________________

Relationship to patient ____

Name/City of Primary Care Physician: _______________________________

How did you hear about our office?

Referral (If so, who may we thank?) ______________________________

Insurance Provider list: _______________ Name of Insurance Carrier: __________

Newspaper Article/Advertisement: _______________ Other: _________________

What brings you to our office today?

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* I hereby authorize "Stephen Cohen, O.D., P.C." to release any information required by my insurance carrier to process any claim for payment. I acknowledge that I am responsible for all non-covered charges. Payment is expected at time of services.

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Responsible Party Date