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)

DOB:_____ **Gender:** ◯M ◯F **Marital Status:** ◯M ◯S ◯D ◯W

Address:

_____

(Street Address)

_____

(City) (State) (Zip Code)

Phone(s):

_____

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

E-Mail: _____

Communication preference: ◯email ◯phone ◯text *(check preferred)*

Race: ◯White/Caucasian ◯AI/Alaska Native ◯Asian ◯AA/Black ◯Hispanic ◯Pacific Islander/Native Hawaiian

Ethnicity: ◯Hispanic ◯Native Hawaiian ◯Not Hispanic/Latino

Names/Ages of Children living at home: _____

Employer/School _____ Occupation/Grade _____

Date of Last Eye Exam:_____ Name/City of Dr. _____

Name/City of Primary Care Physician: _____

Name Vision Ins.: _____ **Member ID:** _____
(IF VSP, LAST 4 OF SOCIAL OF MEMBER)

Medical Ins and/or Supplement: _____ **Member ID:** _____

Employer & Name (Primary Insurance holder) **& Last 4 of SS #:** Primary's Name: _____

Employer: _____ Primary's DOB: _____ Primary's Last 4 SS# _ _ _ _

How did you hear about our office? _____

What brings you to our office today?

_____

_____

** 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.*

_____

(If minor, please **PRINT** Name of Parent/Guarantor)

_____

Signature of Self or Guarantor Date

(Revised Form 03.27.18)