

# PATIENT REGISTRATION

GREG S COHEN MD, LLC • 676 N. SAINT CLAIR ST, SUITE 1525 CHICAGO, IL 60611 • PHONE (312) 695-4452 FAX (312) 695-4453

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date \_\_\_\_\_  
Address (No PO Boxes) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Gender:  Male  Female    Marital Status:  Single  Married  Divorced  Separated  Widowed

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### EMERGENCY CONTACT

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Address (No PO Boxes) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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### PRIMARY CARE PHYSICIAN INFORMATION

Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ Fax \_\_\_\_\_  
 Check here if you were referred by your primary care physician. Otherwise please tell us who referred you: \_\_\_\_\_

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### PERSON RESPONSIBLE FOR THIS ACCOUNT

Check here if the patient is the responsible party. Otherwise fill out the information below.  
Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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### PRIMARY INSURANCE INFORMATION

Please attach your insurance card or a photocopy of the front and back of your insurance card.

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### SECONDARY INSURANCE INFORMATION

Please attach your insurance card or a photocopy of the front and back of your insurance card.

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### CONSENT FOR WORKUP AND TREATMENT

I have come to Greg S. Cohen, M.D. for the purpose of diagnosis and treatment that may include laboratory tests, x-rays, injections, additional diagnostic procedures, referrals, and any gathering of information that is necessary to my care. I understand that no guarantees have been made to me regarding the outcome of my diagnosis or treatment.

#### RETENTION OF INFORMATION

Greg S. Cohen, M.D. may record and retain medical and other information either on paper, electronically, or other physical forms.

#### RELEASE OF INFORMATION

I authorize the release of my medical or financial information orally, on paper, or electronically to Greg S. Cohen, M.D.

#### ACKNOWLEDGEMENTS/DISCLAIMERS/ASSIGNMENT OF BENEFITS

I authorize release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, directly to the doctor.

#### POLICY ON MISSED APPOINTMENTS AND PHONE CALL / EMAIL COMMUNICATION

If you cannot keep an appointment, you must give us 24 hours notice. If you miss your appointment and do not give us notice, our office reserves the right to charge a missed appointment fee. You may be charged a fee for phone calls and emails to the doctor.

I agree to the above terms       I do not agree to the above terms

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Signature (insured or authorized person)

Date