



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] [postal]

Race: [White/Caucasian] [Al/Alaska Native] [Asian] [AA/Black] [Hispanic] [Pacific Islander/Native Hawaiian]

Ethnicity: [Hispanic] [Native Hawaiian] [Not Hispanic/Latino]

Occupation/Grade Employer/School

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

Name/City of Primary Care Physician:

Names/Ages of Children living at home:

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?

\* I hereby authorize "Stephen Cohen, O.D., P.C." to release any information required by my insurance carrier to process the claim, and accept responsibility for all non-covered charges.

Patient or Responsible Party

Date