Mother's Maiden Name: _______________ Due Date _________Hospital: ___________

MATTHEW COHEN, MD, FAAP

Patient Contact Information:

Last Name: ____________________________________First Name: ____

Address: _______________________________City: ______________________State: ______ Zip: ________________

Telephone: (___)__________________(Cell/Home)Date of Birth: _______/_____/______ Sex: ☐ Male☐ Female

Referred By: ____

Emergency Contact: _______________________Relation: __________________Telephone: (___)__________________

Siblings: ____

Medical Information:

Birth History: Weight: _____________ Height: ____________ Delivery Type: Vaginal / C-Section Term: Yes / No

Complications: ____

OB/GYN: ________________________________

Past Medical History:____

____

Known allergies? ☐ Yes ☐ No

If yes, please list all known allergies:

____

Demographics Information:

It is now mandated by federal and local authorities to maintain information on language, race, and ethnicity for all of our patients. Please provide this information below.

Preferred Language: ____________________________________

Race :
- ☐ White
- ☐ Black / African American
- ☐ Asian
- ☐ Native American / Other Pacific Islander
- ☐ American India / Alaska Native
- ☐ Other: _____________________________________
- ☐ I would prefer to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Parent Information:

Mother's Name: _________________________________DOB: ______________Cell: (___)_________________________

SSN: _________-_______-_____________ Email: ___________________________Health: ___________________________

Occupation: _______________________Employer: __________________________ Telephone: (__)___________________

Employer Address: ______________________________City: ______________________State ________ Zip: ______________

PLEASE CONTINUE TO THE NEXT PAGE

Parent Information: *(Continued)*

Father's Name: ________________________________DOB: ______________ Cell: (__)_________________________

SSN: _________-_______-_____________ Email: __________________________Health: _________________________

Occupation: _____________________Employer: _________________________ Telephone: (__)___________________

Employer Address: ____________________________City: ___________________State ________ Zip: _____________

Family History: ____

Insurance Information

Primary Insurance Company: ____________________________Identification #: _______________________________

Name of Insured: ______________________________________Relationship to Patient: __________________________

Subscriber Social Security #: ____________________________Subscriber Date of Birth: _________________________

Secondary Insurance Company: __________________________Identification #: _______________________________

Name of Insured: ______________________________________Relationship to Patient: __________________________

Subscriber Social Security #: ____________________________Subscriber Date of Birth: _________________________

INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature: ____ (Patient, Parent or Guardian) Date: __________________

I hereby authorize Dr. Cohen to apply for benefits on my behalf for covered services rendered by him, or his order. I request that payment from my insurance company be made directly to Dr. Cohen (or the party who acceptsassignment).

I certify that the information I have reported with regard to my insurance is correct.

I permit a copy of this authorization to be used in place of the original. The authorization may be revoked by either me or my insurance company at any time in writing.

Signature: ______________________________________ (Patient, Parent or Guardian) Date: __________________

PLEASE PROVIDE YOUR INSURANCE CARD TO RECEPTION

Federal HIPAA Laws (Health Insurance Portability and Accountability Act)

I have received the notice of Privacy Practices and I have been provided an opportunity to review it.

Signature: ____(Patient, Parent or Guardian) Date: __________________