CHART #: _____________

PATIENT INFORMATION

PATIENT NAME: ____
LAST FIRST MIDDLE

ADDRESS: ______________________________ APT./UNIT/SPACE/STE. : ______________

CITY: ____________________ ZIP CODE: ____________________ STATE: ________

DATE OF BIRTH: ________/_________/___________ SSN: ___________ - ___________ - _________________

HOME PHONE: (______) _______-_______ WORK PHONE: (______) _______-_______ CELL PHONE: (______) _______-________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER GENDER: ☐ FEMALE ☐ MALE

EMAIL ADDRESS: ______________________ @ ____________________ . __________________

EMPLOYER: ______________________________ PHONE #: (______) _______-__________

PRIMARY CARE PHYSICIAN: ______________________________ PHONE #: (______) _______-_________

REFERRED BY: (if different from PCP) ______________________________ PHONE #: (______) _______-_________

SUBSCRIBER / RESPONSIBLE PARTY INFORMATION

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: ☐ **SELF (same as above)** ☐ **Spouse** ☐ **Child** ☐ **Other**

NAME OF SUBSCRIBER/RESPONSIBLE PARTY: ____
LAST FIRST MIDDLE

ADDRESS: ______________________________ APT./UNIT/SPACE/STE. : ______________

CITY: ____________________ ZIP CODE: ____________________ STATE: ________

DATE OF BIRTH: _______/________/___________ SSN: __________ - ___________ - ______________ GENDER: ☐ FEMALE ☐ MALE

EMPLOYER: ______________________________ PHONE #: (_______) ________-___________

INSURANCE INFORMATION

☐ Primary Insurance Card Copied

PRIMARY INSURANCE COMPANY: ______________________________ PHONE:(__________) _________-__________

POLICY/ID NUMBER (INCLUDE ANY LETTERS): ______________________ TYPE OF PLAN: ☐ PPO ☐ POS ☐ EPO ☐ HMO

HMO/MEDICAL GROUP NAME: ______________________________ GROUP NUMBER: ____________________

☐ Secondary Insurance Card Copied

SECONDARY INSURANCE COMPANY: ______________________________ PHONE:(__________) _________-__________

POLICY/ID NUMBER (INCLUDE ANY LETTERS): ______________________ TYPE OF PLAN: ☐ PPO ☐ POS ☐ EPO ☐ HMO

HMO/MEDICAL GROUP NAME: ______________________________ GROUP NUMBER: ____________________

Please read thoroughly, initial, sign and date.

Insurance Policy:

As a courtesy to you we will submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. Insurance provides for your reimbursement on allowed medical charges. **You are responsible for all deductibles, co-insurance and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility. We will be happy to provide an itemized statement you may send to your insurance company for payment.

I hereby authorize payment of medical benefits directly to William C. Cohen, D.O. for services provided. I understand that I may be financially responsible for the charges not covered by this authorization.

Initals: ________

Office Policy on Payment:

It is our policy to require payment of all office charges at the time of service, unless prior arrangements have been specifically made. All copay responsibilities are to be paid upon arrival/check-in process prior to your visit.

Initials: ________

Authorization to Release Medical Records:

I hereby authorize William C. Cohen, D.O. to disclose when requested by the above named insurance carrier(s) or its representatives any and all information with respect to any illness(es), injury(ies), medical history, or treatment and copies of all medical records.

Initials: ________

Consent to Examination

I, ______________________________, hereby authorize, William C. Cohen, D.O., to perform a consultation,
(print name)
physical examination, diagnostic testing and/or therapeutic treatments as necessary to treat my

symptoms/medical condition.

Patient/Parent Signature: ________________________________ Date: ___________

MEDICAL HISTORY FORM

Print Legal Name: ______________________________ **D.O.B.:** ____________

Current Medical Condition:

Reason for seeing the doctor (symptoms): ______________________________

How long have you been experiencing symptoms? : ______________________________

Have you been prescribed medication to treat your symptoms?: ☐ Yes ☐ No

If yes, which medication(s)?: ______________________________

Medication Information:

List **ALL** medications (over the counter/prescribed) that you take regularly: ☐ See attached list ☐ N/A

____

List any medications or injections that you are **allergic** to: ☐ No Known Drug Allergies

____

Preferred Pharmacy: ____________________ **Address:** ____________________

City: ____________ **State:** ____ **Phone: (   )** _____ - _______ **Height:** _____ **Weight:** ______

Medical History: (Please check "YES" or "NO")

	YES	NO		YES	NO
Heart Problems	____	____			
Lung Disease	____	____	High Blood Pressure	____	____
Kidney Disease	____	____	Diabetes	____	____
Thyroid Problems	____	____	Epilepsy	____	____
Bleeding Problems	____	____	Gastrointestinal Problems	____	____
GERD (Acid Reflux)	____	____	Sleep Apnea	____	____
Cancer	____	____	Snoring	____	____
If "yes" give type (location): ______________________			Other Medical Conditions	____	____
			Specify: ______________________		

Previous Surgeries and/or Illnesses:

☐ N/A

____

Family Medical History: (list any illness/medical conditions)

☐ Unknown

____

____

Allergy History:

Have you ever had difficulties with? ☐ Local Anesthesia ☐ General Anesthesia ☐ N/A

If "YES" please explain: ______________________________

Do you have any environmental/food/pet allergies? ______________________________

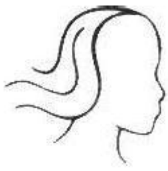
Please list any pets you are in contact with: ______________________________

Social History:

Approximate daily use of: Tobacco: ________ Alcohol: ________ Drugs: _________

If you are not a current smoker, have you ever smoked? ☐ Yes or ☐ No

Date: ____________ **Signature:** ______________________________



William C. Cohen, D.O., Inc., F.A.O.C.O.

Board Certified
Otolaryngology ~ Audiology ~ Allergy ~ Facial Plastic and Cosmetic Surgery

2501 E. Chapman Ave., Ste. 401
Orange, Ca. 92869

1325 N. Rose Dr., Ste. 206
Placentia, Ca. 92870

Phone 714 628-1313 Fax 714 628-1319
www.cohendoc.com

Protected Health Information Disclosure Record

Patient's Name: ________________________________ Date of Birth: ______/_____/_______

*In accordance with current HIPPA laws we are unable to share information regarding your care without your consent. Please assist us in your privacy by completing **ALL** of the following information.

AUTHORIZED METHODS OF COMMUNICATION (check **ALL** that apply)

	OKAY to leave detailed message with person	**OKAY** to leave detailed message on answering machine	**DO NOT** leave message. Leave call back number **ONLY!**
Home Phone Number ( ) -	Yes No ( ) ( )	Yes No ( ) ( )	Yes No ( ) ( )
Work Phone Number ( ) -	Yes No ( ) ( )	Yes No ( ) ( )	Yes No ( ) ( )
Cell Phone Number ( ) -	Yes No ( ) ( )	Yes No ( ) ( )	Yes No ( ) ( )

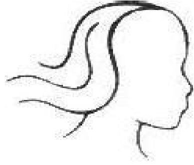
Written Correspondence: **MAIL** Delivery ( ) Yes ( ) No **FAX** ( ) -

Address: ____________________
____
____

AUTHORIZED COMMUNICATION WITH THE FOLLOWING INDIVIDUALS

*Please list any individuals whom we may disclose medical information to: (ex:spouse, family members, friends, etc.)

Name: ____ Relationship: ________________________
Name: ____ Relationship: ________________________
Name: ____ Relationship: ________________________
Name: ____ Relationship: ________________________



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NOTICE OF PRIVACY PRACTICES

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY

Law Requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. If there should be any future changes to this policy, an updated copy will be mailed to you.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information to our health care operations to support the business activities of our practice. We may use medical information about you to review and evaluate our treatment and services or to evaluate our staff`s performance while caring for you.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information about you.

ADDITIONAL USES AND DISCLOSURES:

As required by law. We may use and disclose your health information when required to by federal, state, or local law.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Worker`s Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. If you request copies, we may charge you for the costs of copying, mailing, or other supplies used in fulfilling your request.

2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions. You must request in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years. You are entitled to one list per year without charge. There is a charge for additional lists within the 12 month period.

3. Request that we place additional restrictions on our use or disclosure of your medical information. You may request we do not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

4. Request that we communicate with you about your medical information by different means or to different locations. You may request that we call you only at your work number, or by mail at a special address. Your request must be in writing.

5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

Complaints: If you believe we may have violated your privacy rights, you may file a complaint in writing within 180 days of the suspected violation. You may file this directly with the Secretary of Health and Human Services, or with the Privacy Officer c/o William C. Cohen, D.O., 2501 E. Chapman Ave., Ste 401, Orange, Ca. 92869

PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this form, you acknowledge receipt of the **Notice of Privacy Practices** of **William C. Cohen, D.O., F.A.O.C.O.**

Our **Notice of Privacy Practices** provides information about how we may use and disclose your protected health information.

Our **Notice of Privacy Practices** is subject to change. If there are any changes made, you will receive an updated copy by mail.

I have received the **Notice of Privacy Practices,** and I have reviewed it.

Please Print Name: ____

(patient/guardian/responsible party)

Signature: ____ Date: _____________