

PATIENT INFORMATION

PATIENT NAME: _____
 LAST FIRST MIDDLE

ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE #: (____) _____ - _____ WORK PHONE #: (____) _____ - _____ CELL PHONE #: (____) _____ - _____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER EMAIL ADDRESS: _____

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one) SELF SPOUSE CHILD OTHER SEX: (circle one) FEMALE MALE

PRIMARY CARE PHYSICIAN: _____ OFFICE PHONE #: (____) _____ - _____

REFERRED BY: (if different from PCP) _____ PHONE #: (____) _____ - _____

PATIENT'S EMPLOYER INFORMATION: COMPANY: _____

CITY: _____ PHONE: (____) _____ - _____

ACCIDENT INFORMATION: DATE OF INJURY: ____/____/____ WORK RELATED? _____ AUTO: _____ OTHER: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESP. PARTY NAME: _____
 LAST FIRST MIDDLE

ADDRESS: _____

DATE OF BIRTH: ____/____/____ SEX: (circle one) FEMALE MALE

HOME PHONE #: (____) _____ - _____ WORK PHONE #: (____) _____ - _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION: COMPANY: _____

CITY: _____ PHONE: (____) _____ - _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: (____) _____ - _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAY AMOUNT: \$ _____ INSURED'S DATE OF BIRTH: ____/____/____

SECONDARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: (____) _____ - _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAY AMOUNT: \$ _____ INSURED'S DATE OF BIRTH: ____/____/____

We Appreciate The Opportunity Of Serving You.

We Pledge To Give You Our Very Best Medical Care.

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 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.

Initials

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 at the time of check-in prior visit.

Initials

AUTHORIZATION FOR RELEASE OF 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 and examination and to initiate diagnostic and therapeutic treatments that may be considered necessary upon: _____

Name of Patient

Date

Patient or Guardian's Signature

MEDICAL HISTORY FORM

Current Medical Condition:

Height: _____ Weight: _____

Chief Complaint (reason for seeing doctor today): _____

Duration (how long have you had this problem?): _____

Please list medications taken specifically for this **current** complaint: None

Past Medical History:

Please list **ALL** medications taken regularly for other medical problems: None

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

Have You Ever Had: (Please check "YES" or "NO")

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

Previous Surgeries and/or Illnesses:

Not Applicable

Family Medical History: (any illness or medical conditions)

Unknown

Mother: _____

Father: _____

Siblings: _____

Children: _____

Allergy History:

Have you ever had difficulties with?

Local Anesthesia General Anesthesia Not Applicable

If "YES" please explain _____

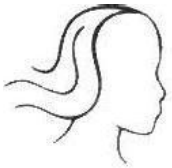
Do you have any environmental/food/pet allergies? _____

Please list any pets you are in contact with: _____

Social History:

Approximate daily consumption of: Tobacco _____ Alcohol _____ Drug Use _____

Date _____ Signature _____



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

2501 E. Chapman Ave., Ste. 401
Orange, Ca. 92869
Phone 714 628-1313 Fax 714 628-1319

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

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)

Table with 3 columns: 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 () ()

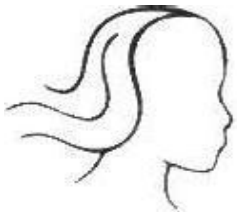
Written Correspondence: MAIL Delivery () Yes () No FAX () -

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: _____



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

2501 E. Chapman Ave., Ste. 401
Orange, Ca. 92869
Phone 714 628-1313 Fax 714 628-1319

*Board Certified
Otolaryngology - Audiology - Allergy
Facial Plastic and Cosmetic Surgery*

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. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

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 we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at 714 628-1313.

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

Name _____
(patient/parent/conservator/guardian)

Signature _____

Date _____