CHART #: _____

PATIENT INFORMATION

NAME: _____ _____ _____
LAST FIRST MIDDLE

ADDRESS: _____ **APT./UNIT/SPACE #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

DATE OF BIRTH: _____/_____/_____ **SSN:** _____ - _____ - _____

HOME #: (_____) _____ - _____ **WORK #:** (_____) _____ - _____ **CELL #:** (_____) _____ - _____

EMAIL: _____ @ _____ . _____ ☐ N/A

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

EMPLOYMENT STATUS: ☐ FULL-TIME ☐ PART-TIME ☐ SELF-EMPLOYED ☐ RETIRED ☐ UNEMPLOYED

EMPLOYER/COMPANY NAME: _____

REFERRED BY: _____ **PHONE #:** (_____) _____ - _____

☐ ***Please check this box to if you wish to sign up for access to our patient portal.***
(Email address OR cell number required).

INSURANCE SUBSCRIBER / PARENT / GUARDIAN

RELATIONSHIP TO PATIENT: ☐ SELF (if same as above, skip this section) ☐ SPOUSE ☐ PARENT ☐ OTHER

NAME OF INSURED: _____ _____ _____
LAST FIRST MIDDLE

BILLING ADDRESS: _____ **APT./UNIT/SPACE #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

DATE OF BIRTH: _____ / _____ / _____ **SSN:** _____ - _____ - _____ **GENDER:** ☐ FEMALE ☐ MALE

EMPLOYER: _____ **PHONE #:** (_____) _____ - _____

INSURANCE INFORMATION

☐ Primary Insurance Card Copied

INSURANCE COMPANY: _____ PHONE:(_____) _____-_____

POLICY ID: _____ TYPE OF PLAN: ☐ PPO ☐ POS ☐ EPO ☐ HMO ☐ OTHER

HMO/MEDICAL GROUP NAME: _____ GROUP NUMBER: _____

☐ Secondary Insurance Card Copied (if applicable)

INSURANCE COMPANY: _____ PHONE:(_____) _____-_____

POLICY ID: _____ TYPE OF PLAN: ☐ PPO ☐ POS ☐ EPO ☐ HMO ☐ OTHER

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 from my insurance directly to, William C. Cohen, D.O., for any services provided. I understand that I may be financially responsible for charges not covered by insurance.

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 co-pay responsibilities are to be paid upon arrival/check-in process prior to your visit.

Initials: _____

Authorization to Release Medical Records:
I hereby authorize the office of, William C. Cohen, D.O., to disclose any and all information with respect to any illness(es), injury(ies), medical history, and/or treatment and copies of all medical records when requested by my insurance carrier(s) and/or its representatives. (This is needed for processes such as authorization requests, pre-certification, billing and displaying proof of medical necessity for requested services.)

Initials: _____

Consent to Examination

I, _____, hereby authorize, William C. Cohen, D.O., to perform a consultation,
(please print name)

physical examination, diagnostic testing and/or therapeutic treatments as necessary to treat my condition.

Patient/Guardian Signature: _____ Date: _____

Patient Health Information

(Please complete the entire form)

What is the reason for this visit?: _____

How long have you had this problem? : _____ ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ Not sure

Have you had testing for this problem? ☐ Yes or ☐ No If yes, where/when? _____

Were you prescribed medication(s) for it?: ☐ Yes ☐ No If yes, which medication(s)?: _____

Preferred Pharmacy (required): _____ ***We send prescriptions electronically***

Address: _____ **City:** _____ **State:** _____

Phone: (_____ **)** _____ - _____ **Height:** _____ feet _____ inches **Weight:** _____ pounds

Medications: List **ALL** medications taken regularly. ☐ See attached list ☐ N/A

_____

Allergies: List any allergies and reactions. ☐ No known drug allergies

_____

Have you ever had difficulties with? ☐ Local Anesthesia ☐ General Anesthesia ☐ N/A
If yes, what was your reaction: _____

Illnesses: (✓ for "YES" or "NO")

	YES	NO		YES	NO
Heart Problems	____	____	High Cholesterol	____	____
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: _____		

Surgical History: List all surgeries you have had. ☐ N/A

_____

Family Medical History: List any known illnesses/medical conditions. ☐ Unknown

_____

Social History: If you are not a current smoker, have you ever smoked? ☐ Yes or ☐ No
Approximate daily use of tobacco: _____ Monthly use of alcohol: _____ , drugs: _____

Print Legal Name: _____ **D.O.B.:** ____ / ____ / ____

Signature: _____ **Date:** _____

Advanced
ENT and Facial Plastic Surgery
William C. Cohen, D.O., FAOCO
1010 W. La Veta Ave. Suite 445, Orange, CA 92868 • 1325 N. Rose Dr. Suite 206, Placentia, CA 92870
Phone (714) 628-1313 • Fax (714) 628-1319
cohendoc.com

Patient Information Disclosure Preferences

In accordance with HIPAA laws, we are required to obtain your written consent if you would like for Dr. Cohen and/or his staff to be able to discuss or disclose information regarding your care with whom you desire.

Please note that if the form is left blank, we can only discuss your information with you (and may not speak with family, friends, etc.).

Patient: _____ Date of Birth: ____ / ____ / _____

Methods of contact: Please ✓ to note preferred forms of communication.

Phone Numbers	Detailed Voicemail	Call Back # Only	No Message
Home: (____) _____ - _____	☐	☐	☐
Work: (____) _____ - _____	☐	☐	☐
Cell: (____) _____ - _____	☐	☐	☐

Only use written correspondence: ☐

Please list the person(s) whom we are authorized to communicate with:
(examples: spouse, boyfriend/girlfriend, children, friends, translator, roommate, etc.)

Name:	Relationship:	Number:
_____	_____	(____) _____ - _____
_____	_____	(____) _____ - _____
_____	_____	(____) _____ - _____
_____	_____	(____) _____ - _____

Advanced
ENT and Facial Plastic Surgery

William C. Cohen, D.O., FAOCO

1010 W. La Veta Ave. Suite 445, Orange, CA 92868 • 1325 N. Rose Dr. Suite 206, Placentia, CA 92870
Phone (714) 628-1313 • Fax (714) 628-1319
cohendoc.com

Notice of Privacy Practices (HIPAA)

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., 1010 W. La Veta Ave., Ste. 445, Orange, CA 92868.

Advanced
ENT and Facial Plastic Surgery
William C. Cohen, D.O., F.A.O.C.O
1010 W. La Veta Ave. Suite 445, Orange, CA 92868 • 1325 N. Rose Dr. Suite 206, Placentia, CA 92870
Phone (714) 628-1313 • Fax (714) 628-1319
cohendoc.com

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: _____

Advanced
ENT and Facial Plastic Surgery
William C. Cohen, D.O., FAOCO
1010 W. La Veta Ave. Suite 445, Orange, CA 92868 • 1325 N. Rose Dr. Suite 206, Placentia, CA 92870
Phone (714) 628-1313 • Fax (714) 628-1319
cohendoc.com

Medical Records Release Form

(Print name and sign if we need to request records at any given time for any reason regarding your care.)

I, _____, provide my consent for the following medical records to be released
(print name)

to Dr. William C. Cohen's office. Please immediately fax these records to (714) 628-1319.

Patient Signature: _____

(Office use only)

Requesting:

- ☐ All medical records
- ☐ Radiology records (ex: reports/films/CD)
- ☐ Lab tests (ex: blood work/pathology)
- ☐ Hospital/Surgical records (ex: operative report)
- ☐ Audiology records (ex: audiogram/ENG/VNG/hearing aid clearance)
- ☐ Sleep study (ex: reports/CPAP/Titration)
- ☐ Other: _____

Requested by: _____ Date: _____