



BENJAMIN R. COHEN, M.D., F.A.C.S.

PATIENT INFORMATION

Name: _____ Age: _____ D.O.B.: ____/____/____
Address: _____ City _____ State ____ ZIP _____
Home (____) _____ - _____ Cell:(____) _____ - _____
Email Address: _____ @ _____ Sex 1M 1F
SSN: _____ - _____ - _____ 1Single 1Married 1Widowed 1Separated 1 Divorced
Occupation: _____ Employer: _____
Employer's Address: _____ City _____ State _____
Referred by _____ Phone: () _____ - _____
Address: _____ City _____ State ____ ZIP _____
Primary Care Physician: _____ Phone: () _____ - _____
Address: _____ City _____ State ____ ZIP _____
Preferred Pharmacy Name: _____ Phone: () _____ - _____
Address: _____ City _____ State ____ ZIP _____
Emergency Contact: _____ Phone: () _____ - _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____
Policy Holder's Name: _____ Policy Holder's DOB: ____/____/____
Policy Holder's SSN: _____ - _____ - _____
Secondary Insurance: _____ ID#: _____
Policy Holder's Name: _____ Policy Holder's DOB: ____/____/____
Policy Holder's SSN: _____ - _____ - _____

Please circle one: **WORKER'S COMPENSATION** or **NO FAULT**

Insurance Company: _____ Insurance Company: _____
DATE OF ACCIDENT: ____/____/____ DATE OF ACCIDENT: ____/____/____
Address: _____ Claim #: _____
Carrier Case #: _____ Adjuster: _____
WCB #: _____ Phone: () _____ Ext: _____
Case Manager: _____