Benjamin J. Cousins, M.D.

Patient Name: ________________________________

Date of Birth: ___/_____/_____Age:______ Sex: M F

Cell phone: (______) ____________________________

Home phone: (______) __________________________

Driver License number: _________________________

Occupation: ___________________________________

Email: ____

Address: ______________________________________

City: ______________State: _____ Zip code: ___________

Social Security Number: _________-__________-_________

Marital Status: S M W D

Spouse's Name: ________________________________

EMERGENCY CONTACT: __________________________

Phone number: (_____) __________________________

If you are the parent or financially responsible for the patient, please complete the following:

Name: _______________________________________

Relationship to patient:

____

Date of Birth: ___/_____/________

Phone: (_____) ________________________________

Address: _____________________________________

City: ______________State: _____ Zip code: ___________

Social Security Number: _________-__________-_________

How did you hear about Dr. Cousins?

____

Reason for your visit: ___________________________

____

Date of injury: _____/______/ __________

Did your accident happen at work? Y N

Did you go to the ER? Y N

Which ER? __________________________________

Date of Hospital Visit: ___________________________

Primary insurance: ______________________________

Policy number: _________________________________

Name of Subscriber: ____________________________

Relationship to patient: __________________________

Subscriber Date of Birth: ___/_____/________

Subscriber Social Security: _____-________-__________

Subscriber Employer: ____________________________

Subscriber Employer Phone: (____) ________________

I hereby authorize payment be made directly to my physician (s) or supplier for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/ or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature: **Date:**

__________________________ ____/ _____/ _______

Parent or Guardian Signature: **Date:**

__________________________ ____/ _____/ _______

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