



Dr. Todd Cohan  
Dr. Kathy Delgadillo

**Return Patients: Please enter only information which has changed since your last visit.**

NONE OF THE INFORMATION BELOW HAS CHANGED SINCE MY LAST VISIT

Privacy: I acknowledge that I received a copy of Dr's Todd Cohan and Kathy Delgadillo Notice of Privacy Practices.

\_\_\_\_\_  
SIGNATURE

**Patient Information:** (Please Print)

(Please circle) Mr. Mrs. Ms. Miss Dr.

Name: \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ M / F Soc Security # \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Phone: Home(\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_

**Insurance Information**

Subscriber's Name \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's relation to Subscriber \_\_\_ Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_\_\_

Subscriber's SS# / ID Number \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

**Vision Insurance:** \_\_\_ VSP \_\_\_ Eyemed

**Medical Insurance:** \_\_\_ BCBS PPO \_\_\_ Humana Choice Care \_\_\_ Medicare  
\_\_\_ Aetna \_\_\_ Cigna \_\_\_ United Healthcare

If you are a member of the above Insurance plans, your insurance company will be billed directly for services/ materials less any applicable deductions (Copays, Co-insurance, etc.). **Please provide your ID cards to the reception desk.** If you have other medical / vision insurance we will be happy to assist you in submitting a claim on your behalf for reimbursement to you.