

**Aventura Orthopaedics and Sports Medicine, P.A.**  
**Brad K. Cohen, M.D.**

**PATIENT INFORMATION**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone (evening): \_\_\_\_\_ Home phone(daytime): \_\_\_\_\_  
Permanent address: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**EMPLOYER**

Company name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, & Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_

**CONTACT INFORMATION**

Nearest Relative not living with you: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

**REFERRING PARTY**

Name \_\_\_\_\_  
City, State, & Zip: \_\_\_\_\_  
Telephone #: \_\_\_\_\_

**FAMILY PHYSICIAN** (if different from referring party)

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, & Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_

**INSURANCE INFORMATION** (must be completed entirely)

Primary Insurance: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Do you use any tobacco products? (please circle)	Yes	No
Do you have any history of peptic ulcers or GI bleeding?	Yes	No
If female, is there any possibility that you may be pregnant?	Yes	No

**AUTHORIZATION**

I authorize release of medical information to process claims to my insurance company and request that benefits be paid directly to the provider of services. I understand and agree that regardless of my insurance sources, I am ultimately responsible for the balance of my account for any professional services rendered. If my account is not paid timely, I agree to be responsible for all cost of collection including reasonable attorney fees and costs. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_