



Robert Graper, M.D. F.A.C.S.

PATIENT INFORMATION

Name: (first middle last) _____

Address: _____
 Street name & # Apt # City, State ZIP

SS# _____ **Married/Single** _____ **DOB:** _____ **Male/Female** _____
 (circle one) (circle one)

Who are you consulting with today? Dr. Graper Melissa Myers Angie Thomas Carla Smith
 Teri Trudnak Linda Cochran Candace Werkman Jan Sizemore (Please circle one)

Home Phone #: _____ **Work Phone #:** _____
 Can we call you at home? **Y** **N** Can we call you at work? **Y** **N**
 Can we leave a message for you at your home? **Y** **N** Can we leave a message for you at work? **Y** **N**

Any other numbers where you can be reached: _____
 (Please circle one: pager cell other: _____)

E-mail address: _____

Emergency Contact Name: _____

Phone #: _____ **Relationship to patient:** _____
 Work # Home #

Patient's Employer Name: _____ **FT or PT?** _____

Who referred you to our office, or how did you hear about Graper Cosmetic Surgery?

Friend: (who) _____	Today's Charlotte Woman _____	Direct Mail _____
Doctor: (who) _____	Skirt Magazine _____	Email _____
Seminar: _____	SouthPark Magazine _____	Office Website _____
American Society of Plastic Surgeons _____	Charlotte Living Magazine _____	Locate a Doc _____
Bob & Sheri 107.9 The Link _____	Charlotte Place Magazine _____	YourPlasticSurgeryGuide.com _____
Radio Other _____	Charlotte Magazine _____	Implantinfo.com _____
	Magazine Other _____	Liposite.com _____
The Charlotte Observer _____	TV _____	LookingYourBest.com _____
Creative Loafing _____	Yellow Pages _____	Google Search _____
Newspaper Other _____	Movie Theatre _____	Internet Other _____

Financial Responsibility: I understand that I am ultimately responsible for the balance on my account for any professional services rendered regardless of insurance coverage.

Authorization to Release Information: I hereby authorize Graper Cosmetic Surgery to release any information acquired in the course of my examination or treatment to the insurance carrier involved in the payment of my account. I authorize fax transmittal as needed.

Assignment of Benefits: I hereby authorize payment directly to Graper Cosmetic Surgery for medical benefits.

Date: _____ **Signature:** _____