



GRAPER
COSMETIC
SURGERY

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:** _____