



Robert Graper, MD FACS  
Garrett Harper, MD

## Patient Information

<b>Name:</b> (first middle last) _____			
<b>Address:</b> _____			
Street name & number	Apt #	City, State	Zip
<b>SS#</b> _____	<b>Married/Single</b> _____	<b>DOB:</b> _____	<b>Male/ Female</b> _____
	(circle one)		(circle one)
<b>Who are you consulting with today?</b> Dr. Graper Dr. Harper Melissa Myers Angie Thomas Carla Smith Teri Trudnak Linda Cochran Candace Werkman Kristen Hall (Please circle one)			
<b>Home Phone #:</b> _____		<b>Work Phone #:</b> _____	
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	
<b>Any other numbers where you can be reached:</b> _____ (Please circle one: cell other: _____)			
<b>Email address :</b> _____			
<b>Emergency Contact Name:</b> _____			
<b>Phone #:</b> _____		<b>Relationship to patient:</b> _____	
Work #	Home #		
<b>Patient's Employer Name:</b> _____			<b>FT or PT?</b> _____
<b>Who referred you to our office, or how did you hear about Graper Cosmetic Surgery?</b>			
Friend: (who) _____	Instagram _____	SouthPark Magazine _____	
Doctor: (who) _____	RealSelf.com _____	CharlotteMagazine.com _____	
Google Search _____	New Beauty Magazine _____	Bob & Sheri 107.9 The Link _____	
Practice Website _____	The Scout Guide _____	YourPlasticSurgeryGuide.com _____	
Seminar _____	TV _____	LiquidFacelift.com _____	
Internet _____	CharlotteLivingMagazine.com _____	DermalFillerNews.com _____	
American Society of Plastic Surgeons _____	Charlotte Five _____	YP.com _____	
Email _____	Charlotte Agenda _____	Other _____	
Facebook _____	CharlotteObserver.com _____	_____	

**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 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: \_\_\_\_\_