Jeffrey S. Rosenthal, M.D.
Rosenthal Cosmetic Surgery & Skin Care Center
75 Kings Highway Cutoff Fairfield CT 06824
203 335-FACE (3223)

PATIENT BUSINESS INFORMATION

PATIENT: Name: ______________________ ______________________ ________
Last First Middle Initial

Address: ______________________ ______________________ ________ ________
Street City State Zip Code

E-Mail: ______________________

□ Check here if you would prefer *not* to receive e-mail notification of new services/products, events and promotions offered by Rosenthal Cosmetic Surgery & Skin Care Center

Date of Birth: ______ /______ /______ SS #: ______________________

Telephone (H) ______________ (B) ______________ (Cell) ______________

Family Physician: ______________________ City/State ______________________

Occupation: ______________________ Employer: ______________________

Employer's Address: ______________________

Single _____ Married _____ Name of Financially Responsible Party: ______________________

SPOUSE: Name: ______________________ SS #: ______________________

Employer: ______________________ Telephone: ______________________

Employer's Address: ______________________

IF PATIENT IS A MINOR:

Mother's Name: ______________________ Father's Name: ______________________

Address: ______________________ Address: ______________________

SS #: ______________________ SS #: ______________________

Employer: ______________________ Employer: ______________________

Telephone: ______________________ Telephone: ______________________

IN CASE OF AN EMERGENCY PLEASE NOTIFY: Name: ______________________

Telephone #: (H) ______________________ (B) ______________________

Relationship: ______________________

I accept full responsibility for payment of all services rendered by Jeffrey S. Rosenthal, M.D., and authorize my insurance benefits to be paid directly to his office, when applicable. Additionally, I agree to pay all costs of collection, including reasonable attorney's fees.

I consent to being photographed as part of the overall plan and evaluation for any future surgery. These photographs will be property of Dr. Rosenthal.

I also authorize the physician to release any information/photographic material required for didactic (teaching), medical, and payment purposes.

I understand that these photographs will be used in such a way as to conceal my identity.

______________________ ______________
GUARANTOR AND/OR PARENT **DATE**