AESTHETIC & RECONSTRUCTIVE PLASTIC SURGERY PA

(772) 562-5859

Patient s Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes **Ref Physician:** _____

Contact Restrictions: _____ **Family M.D:** _____

Age _____ Birthdate _____ SS# _____ Gender ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Patient s Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

How did you hear about Dr. Rosato MD? (Mark all that apply)

❒ TV News ❒ TV Ad ❒ Phone Book ❒ Magazine ❒ Newsletter ❒ Seminar ❒ Salon ❒ Web

❒ Friend/Relative: _____ ❒ Doctor: _____ ❒ Other: _____

If you were referred by a specific person, may we thank them? ❒ Yes ❒ No

If would you prefer to be contacted by email for appointments, updates, etc. please list emailaddress below:

_____

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Insurance Information: (If insurance is in spouse s name)

INSURED S NAME:_____ **DOB:**_____

SOCIAL SECURITY:_____ **RELATIONSHIP TO PATIENT:**_____

HIPPA Acknowledgement

Ralph Rosato, M.D. has provided me with a copy of my rights as a patient under the HIPPA act. I have been provided the opportunity to read and understand my rights .and ask questions regarding my rights and receive answers to my satisfaction.

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Rosato MD to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Rosato MD and myself.

Signature _____ **Date:**

FINANCIALLY RESPONSIBLE PERSON: