Jeffrey S. Rosenthal, M.D.
Rosenthal Cosmetic Surgery & Skin Care Center
140 Sherman Street, Fairfield, CT 06824
Phone: 203 335-3223 Fax: 203 335-9966

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

Driver's License #:_____ State:_____ Expiration Date _____

Date of Birth: _____ /_____ /_____ SS #: _____

Telephone (H) _____ (B) _____ (Cell) _____

Family Physician: _____ City/State _____

Occupation: _____ Employer: _____
Employer's Address: _____

Single _____ Married _____ Name of Financially Responsible Party: _____

IN CASE OF AN EMERGENCY PLEASE NOTIFY: Name: _____
Telephone #: (H) _____ (B) _____
Relationship: _____

SPOUSE: Name: _____ SS #: _____
Employer: _____ Telephone: _____
Employer's Address: _____

PLEASE FILL OUT IF HAVING SURGERY:

IF PATIENT IS A MINOR:

Mother's Name: _____	Father's Name: _____
Address: _____	Address: _____
_____	_____
SS #: _____	SS #: _____
Employer: _____	Employer: _____
Telephone: _____	Telephone: _____

INSURANCE INFORMATION: Ins. Co. Name _____ ID # _____ Group #_____
Insurance Co. Address: _____ Phone # _____

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**