Jeffrey S. Rosenthal, M.D.

Rosenthal Cosmetic Surgery & Skin Care Center

Rosenthalcosmetic@gmail.com

PATIENT BUSINESS INFORMATION

Name: ______________________________ ______________________________ ________

Last First Middle

Address: ______________________________ ____________________ ____ _________

Street City State Zip Code

Phone: (H) __________________________ (B)______________________ (C) ______________________

E-Mail: _______________________________________

I give my consent to be contacted via phone, text or email as means of communicating future information, updates, scheduling and other pertinent information between myself and Dr. Rosenthal/Cosmetic Surgery Center.

Occupation: ____

IN CASE OF AN EMERGENCY PLEASE NOTIFY:

Name: ____

Phone #: (H) ___________________________ (C) _______________________

Relationship: ____

SPOUSE or SIGNIFICANT OTHER: **Name**:
____

Phone: _________________________

IF PATIENT IS A MINOR:

Mother's Name: ___________________________

Cell: ________________ Home: _________________

Father's Name: ___________________________

Cell: _________________ Home:_________________

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**