Graper • Harper
Cosmetic Surgery

Robert Graper, MD FACS • **Garrett Harper**, MD

Patient Information

Name: (first middle last) _____

Address: _____
Street name & number Apt # City, State Zip

SS# _____ **Married/Single** (circle one) **DOB:** _____ **Male/ Female** (circle one)

Who are you consulting with today? Dr. Graper Dr. Harper Melissa Myers Angie Thomas Carla Smith Teri Trudnak Linda Cochrane Owens Candace Werkman Kristen Hall (Please circle one)

Home Phone #:_____
Can we call you at home? Y N
Can we leave a message for you at your home? Y N

Work Phone #: _____
Can we call you at work? Y N
Can we leave a message for you at work? Y N

Any other numbers where you can be reached: _____
(Please circle one: cell other: _____)

Email address : _____

Emergency Contact Name: _____

Phone #: _____ **Relationship to patient:**_____
Work # Home #

Patient's Employer Name: _____ **FT or PT?**

Who referred you to our office, or how did you hear about Graper Cosmetic Surgery?

Facebook_____
Instagram_____
Google Search_____
Practice Website _____
Internet _____
Email_____
RealSelf.com_____
CharlotteLivingMagazine.com _____
Charlotte Five _____
Charlotte Agenda _____

CharlotteObserver.com _____
SouthParkMagazine.com _____
CharlotteMagazine.com _____
Scoop Charlotte_____
New Beauty Magazine _____
The Scout Guide _____
Bob & Sheri 107.9 The Link_____
American Society of Plastic Surgeons __
YourPlasticSurgeryGuide.com _____
Seminar_____

Day of Beauty Event_____
Just Us Girls Event _____
Ballantyne Seminar_____
Insurance Company _____
Doctor: (who) _____
Friend: (who) _____
Hospital_____
Yelp_____
Other _____

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: _____

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