Craig S. Rock, M.D., P.A.
PATIENT INFORMATION QUESTIONNAIRE

***Please print*:**

Patient Name:	Responsible Party:
Address:	Address:
City, State, Zip:	City, State, Zip:
Sex: Birth Date:	Sex: Birth Date:
Home Phone:	Home Phone:
Cell phone:	Cell phone:
Business Phone:	Business Phone:
Employer:	Employer:
Social Security #: Marital Status:	Social Security #: Marital Status:
E-Mail:	Relationship to Patient:

How may we contact you? (*please circle*): Home Work Cell Text **All**

May we contact you regarding practice news / special offers via e-mail? Yes / No
(No patient specific information will be sent via e-mail)

Family Physician: _____

Reason for consultation: _____

Referred by: _____

I represent to the physician and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by Craig S. Rock, MD.

I understand that photography is a necessary part of planning and evaluating cosmetic and reconstructive surgery. I authorize photographs to be taken at the discretion of my surgeon. These photographs will be used solely for documentation purposes and will be kept confidential.

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

Signature _____ **Date** _____

Relationship (*circle one*) Patient Spouse Parent Guardian

Insurance Coverage: The benefits paid by insurance companies for plastic surgery vary greatly from carrier to carrier and plan to plan. Therefore, we will make every effort to determine in advance what benefits are available under you plan. We ascertain the projected insurance payment and the required co-payment. Please provide a copy of your insurance card.

I hereby authorize Craig S. Rock, M.D., P.A. to furnish information to insurance carriers concerning my illness and treatments. I hereby assign to the physician all payments for medical and surgical services rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ _____

Signature of Responsible Party **Date**