COSMETIC SURGICAL ART CENTER

PATIENT INFORMATION

ROBERT I. MAROUK, D.O.
BOARD CERTIFIED
Cosmetic Surgeon

Date_______________

Please Print

Patient's Name ____ Male__________ Female___________

Address ______________________________________ City _______________ State ________ Zip__________

Out of State Address ____

E-mail Address ____ Birth Date: ____________________

Marital Status: □ Single □ Married □ Divorced □ Widowed

Best Telephone Number to reach you at ____

Telephone (Home) ___________________ (Work) ___________________ Occupation ____________________

Employer's Name _________________________ Address ____

Are you currently covered by health insurance? (□ Yes □ No) Insurance Plan ________________________

Family Physician ____ Telephone _____________________

Parent / Spouse's Name ____ Birth Date: ____________________

How did you hear about us? ____

Nearest Relative or Friend Not Living With You: (Emergency Contact)

Name __________________________ Relationship _____________________ Telephone ___________________

AUTHORIZATION TO TREAT

I hereby give my permission to Dr. Robert Marouk to administer treatment and to perform procedures as may be deemed necessary in the diagnosis and/or treatment of myself or my dependents.

Patient's Signature ____ Date Signed ____________________
(Parent if Patient is a Minor)

Received By ____________________