



Kevin G. Rose M.D.

Name: \_\_\_\_\_ SS# \_\_\_\_\_ Date: \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Weight \_\_\_\_ Age \_\_\_\_ Ht. \_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Home Phone#: ( ) \_\_\_\_\_ - \_\_\_\_\_

Work #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_

Place of employment: \_\_\_\_\_ Insurance Co. name \_\_\_\_\_

Emergency Contact # :( ) \_\_\_\_\_ - \_\_\_\_\_ Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have any known medical allergies? \_\_\_\_\_

Current Medications (Prescription, over-the-counter, or herbal supplements)  
\_\_\_\_\_

What will we be seeing you for/procedure of interest?: \_\_\_\_\_

Who is your Primary Care Physician or Referring Physician? \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

I authorize The Rose Clinic to contact me, at the above number(s) and address(s) for correspondence, messages or appointments. I understand I am responsible for my account being paid in full. I agree that The Rose Clinic can add collection costs up to 50%, attorney's fees, court costs and interest, at the rate of 1.5% per month to my outstanding balance whether or not a lawsuit or arbitration is commenced.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*How did you hear about us?: \_\_\_\_\_

**Board Certified by the American Board of Plastic Surgery**

