

**Robert Kotler, M.D., Inc.**  
9735 Wilshire Blvd., Suite 220 Beverly Hills, CA 90212  
**(310) 278-8721**

**Patient Information**

**(Please Print)**

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail\*\* \_\_\_\_\_

Preferred Number: Home Cell (Circle One)

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DL# \_\_\_\_\_ SS# \_\_\_\_\_

Marital Status: Married Single Divorced Widowed / Spouse's Name: \_\_\_\_\_

**If Minor:** Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Mother's Cell: \_\_\_\_\_ Father's Cell: \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

How did you learn about Dr. Kotler?: \_\_\_\_\_

If referred by a friend or family member, may we send them a thank you card?  YES  NO

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Insurance Information**

HMO or PPO? If PPO please fill out below:

1. Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Subscriber #: \_\_\_\_\_ Telephone: \_\_\_\_\_

2. Co-Insurance: \_\_\_\_\_ Group #: \_\_\_\_\_

I am also interested in the following:

\_\_\_\_\_ Cosmetic Nasal Surgery for Appearance

\_\_\_\_\_ Neck Sculpturing

\_\_\_\_\_ Functional Nasal Surgery for Breathing

\_\_\_\_\_ Chin Augmentation

\_\_\_\_\_ Permanent Non-Surgical Rhinoplasty

\_\_\_\_\_ Face and Neck lift

\_\_\_\_\_ Plastic Surgery of Ears

\_\_\_\_\_ Non-Surgical Facial Rejuvenation (Chemical Skin Peel)