

# Patient Testimonial Form

*Thank you for taking the time to share your experience with Ocean Obstetric & Gynecologic Associates, LLC. We value and appreciate your expression. Your success story may serve as an inspiration and encouragement to others who are struggling with the very same condition.*

**Tell us your story...**

**Here are some questions to reflect on...**

1. How has the care or procedure you received benefitted you and how has it impacted your life?

2. Would you recommend our office or the specific procedure you received to a friend or relative?  
Why?

3. What do you consider to be the most valuable aspect of your experience with us?

4. If you've had experience with other providers, what sets us apart from them?

*Please use the back of this form if additional space is needed.*

**Please circle the provider or surgeon involved in your treatment:**

**JACK R. GOULD D.O., F.A.C.O.G.  
BRIAN J. ROGERS M.D., F.A.C.O.G.  
RONALD L. COHEN M.D., F.A.C.O.G.**

**CRAIG E. HENDERSON D.O., F.A.C.O.G.  
JOHN P. VACLAVIK M.D., F.A.C.O.G.  
ARLENE Z. ROSENBERG N.P.C.**

**Name:** \_\_\_\_\_

**Address (City/Town):** \_\_\_\_\_

**Current/Former Occupation:** \_\_\_\_\_

*By signing below, you are consenting to Ocean Obstetric & Gynecologic Associates, LLC use and disclosure of the information in your testimonial and acknowledgement that the testimonial may be used, all or in part, in our advertising, publications, website, etc. both now and in the future.*

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

*Thank you for submitting your story!*