Bulan Plastic Surgery, PA
75 Main Street, Suite 105, Millburn, NJ 07041

Patient Information Form

Name: _____ DOB: _____ Date: _____

Age: _____ Parent, Guardian, or Emergency Contact: _____

Address: _____ City:_____ State:___ Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail: _____ SS Number: _____

Occupation: _____ Employer: _____

Employer address: _____ Phone: _____

Insurance Information

Please note that it is the patient's responsibility for payment of your bill. We may or may not be participating with your insurance plan. As a courtesy, we are happy to assist you in filing the insurance forms. However, it is your responsibility to keep in touch with your insurance company regarding reimbursement of your account. Payment for office visits and consultations are expected at the time of the visit.

Primary Carrier:_____ Phone:_____

ID#: _____ Group #: _____ Deductible & Co-pay: _____

Address: _____ Name of Guarantor: _____

Secondary Carrier:_____ Phone:_____

ID#: _____ Group #: _____ Deductible & Co-pay: _____

Address: _____ Name of Guarantor: _____

If applicable:

Automobile Insurance Carrier: _____ Name of Insured: _____

Date of accident: _____ Claim #: _____ Name of Adjuster: _____

Insurance Address: _____

Workers Compensation:

Employer: _____ Address: _____

Insurance Carrier: _____ Address: _____

Date of accident: _____ Claim #: _____ Name of Adjuster: _____

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Medical and Assignment of Benefits Release Form

I, [print] _____, authorize Bulan Plastic Surgery ("My Health Care Provider") to submit claims to my insurance carriers on my behalf. I also authorize assignment of all health insurance benefits to which I am entitled to by my insurance plan(s) to be paid directly to My Health Care Provider for any services rendered. I understand that the contract with any insurance carrier is between me and the specified carrier(s). I also understand that I am financially responsible for all charges, whether or not I am insured at the time of service including deductibles, coinsurance, co-payments and benefit services that are out of network, denied and/or not covered by my health insurance plan. In the event that my account is unpaid and/or neglected, it will be turned over to the office attorneys and legal action may be taken. Legal expenses, as well as interest, will be added on to any unpaid account.

I hereby authorize and direct my insurance carrier to make all such payments directly to My Health Care Provider for all claims for such services submitted. Such payment should be forwarded by my insurance carrier directly to My Health Care Provider at the address below, in the form of a check payable to Bulan Plastic Surgery or Dr. Erwin Bulan. I understand and agree that, if the check is made payable to Bulan Plastic Surgery and me, that I promptly will take such action as requested by My Health Care Provider to endorse the check so that Bulan Plastic Surgery can be paid for services rendered.

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I authorize My Health Care Provider to release to my insurance carriers or their authorized agents any information needed for this claim or a related claim. I authorize my insurance company to release detailed copies of the Explanations of Benefits to My Health Care Provider upon their request. I also authorize the release of any adjustments or reviews by the insurance company to the doctors upon their request. This is inclusive of any audits of the doctors' bill requested by my insurance carrier. This assignment and authorization in no way releases me from my responsibilities indicated above, and imposes no obligation on Bulan Plastic Surgery to collect money on my behalf.

I give my permission for photographs to be taken and used for medical purposes, as well as any other purpose that my physician deems proper in the interest of medical education, knowledge, or research. I understand that in any such use I shall not be identified by name. I further grant permission for the use of my record, illustration and photographs for purposes required by the American Board of Plastic Surgery, Inc.

I HEREBY SIGNIFY THAT I HAVE PROVIDED INFORMATION THAT IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND THAT I AM AWARE OF MY RESPONSIBILITIES REGARDING RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS. A PHOTOCOPY OF THIS AGREEMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Patient's Name: _____

Patient/Guardian Signature: _____

Primary Insured's Signature (if different): _____

Patient's Social Security #: _____

Date: _____

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Patient Medical History

Name:_____ DOB: _____ Age: _____

Primary Care Physician: _____ Phone number: _____

PCP Address: _____

Referral information:
If you were referred to our office, kindly state the
Name and address of the referring party.

Do you have allergies to any medications? No _____ Yes _____
If so, please state and describe reaction

Medications No _____ Yes _____
(including vitamins and herbal supplements)

Have you taken Accutane in the past 12 months No _____ Yes _____

Are you taking Inderal? No _____ Yes _____

Patient Past Medical History:
List current and past medical problems, illnesses or hospitalizations

	yes	no		yes	no		yes	no
Heart Disease			AIDS or HIV+			Asthma		
High Blood Pressure			Hepatitis			Glaucoma		
Mitral Valve Prolapse			Hx of excessive bleeding			Stomach ulcers		
Heart Murmur			Anemia			Kidney Disease		
Diabetes			Hx of blood transfusion			Thyroid Disorder		
Cancer			Tuberculosis			Depression		

Please explain any Yes responses, or any additional medical issues not addressed above:

Have you ever had surgery before? No _____ Yes _____
Please list surgeries and dates:

Have you seen a Plastic Surgeon prior to this consultation? If so, please state physician and reason for evaluation. No _____ Yes _____

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Name: _____

Review of Symptoms: Do you presently have, or have had within the past year:

	yes	no		yes	no		yes	no
Weight changes			Headaches			Dry eyes		
Chest pain			Fever sores/ blisters			Phlebitis		
Shortness of breath			Sleep apnea			Changing skin lesions		
Rapid heart beat			Chronic sinus problems			Easy bleeding		
Swollen feet/ankles			Difficult nasal breathing			Easy bruising		

Please explain any Yes responses:

Family Medical History:

	yes	no		yes	no		yes	no
Heart Disease			AIDS or HIV+			Tuberculosis		
High Blood Pressure			Kidney Disease			Bleeding disorders		
Diabetes			Liver Disease			Depression		
Cancer			Hepatitis			Thick scars		

Please explain any Yes responses, or any additional family medical issues not addressed above:

Social History:

Do you smoke? (type and amount per day) _____

Do you drink alcohol? (type and amount per day) _____

Married _____ Single _____ Divorced _____ Widowed _____

Do you have children? Number _____ Ages: _____

Occupation _____

I verify that the above information is true to the best of my knowledge.
I will notify you of any changes in my status or the above information.

_____ _____

Signature of Patient or Parent if Minor Date

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CONSENT FOR INSURANCE SUBMISSION
CureMD BILLING SERVICE

I hereby direct CureMD, the billing company used by Bulan Plastic Surgery, to process insurance claims and to represent my interests against my insurance company, which shall include, filing an Appeal for claims submitted by the Practice on my behalf for insurance non-payment and or lesser payment. I fully understand that I am giving permission to CureMD to act as my advocate in attempting to collect payment from my insurance company.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____

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TCPA Consent Form

To comply with the Telephone Consumer Protection Act, consent is required to send our patients non-emergency SMS text messages on their mobile device(s).

☐ Yes, I consent to receive automated phone calls and text messages from Bulan Plastic Surgery, PA

☐ No, I do not consent to receive text messages from Bulan Plastic Surgery, PA

Consent shall continue during the period you are a patient unless revoked by me in writing.

_____ : Cell phone number to be associated with patient's chart.

_____	_____	_____
Date	Patient/Guardian signature	Printed name