BLOOMFIELD PLASTIC SURGERY

Specialists in the Art of Cosmetic and Reconstructive Surgery

Julio M. Sosa, M.D._____

Patient Information

Date_____

Patient_____

Address_____

_____
City State Zip

Email_____

Sex: ☐ M ☐ F Age_____ Birth date____/____/____

Are You: ☐ Left-Handed ☐ Right-Handed

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address

Employer Phone_____

Spouse's Name_____

Birth date_____

Occupation_____

Spouse's Employer_____

Race: ☐ White ☐ African American ☐ Caucasian ☐ Other_____

Ethnicity: ☐ Filipino ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino

Language: ☐ English ☐ Spanish ☐ Arabic ☐ Albanian ☐ Other_____

Whom may we thank for referring you? Dr._____

Phone#_____Address_____

☐ Pt. refused

Phone Information

Home Number:_____

Work Number:_____ Ext._____

Best time to reach you:_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Home Phone_____

Work Phone_____

Job or Related Insurance Information

Were you injured at work? ☐ Yes ☐ No

If yes, name of Comp Carrier_____

Date of Injury____/____/____

Contact Person_____

Phone#_____

Were you injured in an auto accident? ☐ Yes ☐ No

Date of Injury____/____/____

Agent Name_____Phone#_____

Claim Number_____

Insurance Information

Name of **Primary** Insurance_____

Policy Holder Name_____

Policy Holder Birth date____/____/____

Contract or Policy Number_____

Group Number_____Service Codes_____

Name of **Secondary** Insurance_____

Policy Holder Name_____

Policy Holder Birth date____/____/____

Contract or Policy Number_____

Group Number_____Service Codes_____

Authorizations

Assignment & Release

The undersigned certify that I (or my dependent) have insurance coverage with_____and assign directly to Dr._____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr._____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care FInancing Administration and its agents any information needed to determine these benefits of the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature/Relationship Date