The John Bull Center for Cosmetic Surgery and Laser Medi Spa

Patients Legal Name:____
Last First Middle

Address:____
Street & Apt # City State Zip Code

Is it okay to receive mail at the above address from the John Bull Center ( ) Yes ( ) No

Phone:_____________________________ Any restrictions for contacting you ( ) Yes ( ) No

Email:____

Age:__________ Birthday:____/____/____ SS#____________________ Sex: ( ) Female ( ) Male

Race: ( ) White ( ) Black ( ) Hispanic ( ) Asian ( ) Indian ( ) Native American ( ) Eskimo ( ) Other ( )
Marital Status: ( ) Single ( ) Married ( ) Widowed

Emergency Contact:____________________Relationship:__________Phone:______________

Employer:______________________________________Occupation:____________________

Work Phone:_____________________________ Is it okay to contact you at work? ( ) Yes ( ) No

Work Address:____
Street & Suite # City State Zip Code

Emergency Contact:____
Name Phone Relationship to Patient

Primary Health Insurance Company:____

Policy #:____________________ Group #:______________ Insurance Co. Phone#:______________

Insured Name:____________________ Insured DOB:__________ Insured Employer:______________

Referral Required ( ) Yes ( ) No Copay $: ______________

Secondary Health Insurance Company:____

Policy #:____________________ Group #:______________ Insurance Co. Phone#:______________

Insured Name:____________________ Insured DOB:__________ Insured Employer:______________

Referral Required ( ) Yes ( ) No Copay $: ______________

Referred By:______________________________ Phone:______________________________

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Do you take any medications on a regular basis?
If yes, please list and include dosage.

____
____
____

Are you allergic to any medications, latex, or rubber?
If yes, please list and note reactions.

____
____
____

Do you have any health problem?

____
____
____

Please list any surgeries you have had.

____
____
____

Have you or a blood relative ever had any problems
With anesthesia? If yes, please list and note reactions.

____
____
____

Do you smoke? If yes, please list years smoked and
How much?

____
____

Do you drink alcohol? If yes, how often?

____
____

Do you us illicit drugs? If yes, how often?

____
____

Have you been vaccinated for Covid?

____

Have your ever been pregnant? If yes, please list the
number of pregnancies and live births.

____
____
____

Height:__________ Weight:__________ BP:_____________

Pharmacy:____

Patients Initials:___________________

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Patient Family History

	YES	Afflicted Family Member	Notes
Pt. Denies Any Contributing Family History	( )	______	______
Abnormal Bleeding	( )	______	______
Abnormal Clotting	( )	______	______
Anesthesia Problems	( )	______	______
Autoimmune Disorders	( )	______	______
Breast Cancer	( )	______	______
Brain Tumor	( )	______	______
Other Cancer	( )	______	______
Cleft Lip	( )	______	______
Cleft Palate	( )	______	______
Diabetes	( )	______	______
Drug Allergies	( )	______	______
Endocrine Disease	( )	______	______
Hearing Loss	( )	______	______
Heart Disease	( )	______	______
High Blood Pressure	( )	______	______
Hemophilia	( )	______	______
Kidney Disease	( )	______	______
Liver Disease	( )	______	______
Lung Cancer	( )	______	______
Malignant Hyperthermia	( )	______	______
Ovarian Cancer	( )	______	______
Prostate Cancer	( )	______	______
Skin Cancer	( )	______	______
Skin Disease	( )	______	______
Substance Abuse	( )	______	______
Von Willebrand	( )	______	______

Other:____

____

____

Patient Initials:______________

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Patients Legal Name:____DOB:_______/_______/_________

I WOULD LIKE TO LEARN MORE ABOUT (PLEASE CHECK ALL THAT APPLY)

( ) Abdominoplasty (Tummy Tuck)

( ) Liposuction (Fat Reduction)

( ) Labiaplasty (Vaginal Rejuvenation)

( ) Breast Augmentation

( ) Breast Lift

( ) Breast Reduction

( ) Thigh Lift

( ) Rhinoplasty (Nose Reshaping)

( ) Blepharoplasty (Eyelid Surgery)

( ) Brow Lift

( ) Fact Lift

( ) Chin Implant

( ) Brachioplasty (Arm Lift)

( ) Coolsculpting

( ) Botox

( ) Injectable Fillers

( ) Laser Skin Resurfacing

( ) Age Spots / Liver Spots

( ) Laser Treatments

( ) Facial Vein Removal

( ) Spider Vein / Leg Vein Treatment

( ) Hair Removal

( ) Latisse (Eyelash Enhancement)

( ) Facials

( ) Pharmaceutical Skin Care

( ) Microdermabrasion

( ) Chemical Peels

( ) Other:_______________________________

When looking at my face, the first thing I notice is:____

When looking at my body in a mirror, the first thing I notice is:____

Please list any concerns you may have about surgery:____

Would you be interested in learning about alternative financing options for cosmetic procedures? ( ) Yes ( ) No

Please List any other questions you have for us:____

____

Patients Initials:______________

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I have been provide with a copy of the "Notice of Health Information Privacy Information" that provides information about how the information that I have provided may be used and disclosed and how to get access to this information.
I understand that this authorization is voluntary and that I may refuse to sign this authorization.
I understand that I may revoke this authorization at anytime and will notify the healthcare facility in writing of such revocation of this authorization.
I authorize the use or disclosure of my individually identifiable health information to provide treatment, payments and regular health operations conducted by William John Bull Jr. MD at DuPage Plastic Surgery, LTD, 1307 Macom Drive, Naperville, Il 60564.
I give permission for the following person(s) listed below to access any health information provided to Dr. Bull and Staff.

Patients Initials:_____________

Name:____ Relationship to Patient:__________________________________

Name:____ Relationship to Patient:__________________________________

Assignment of Benefits

The undersigned hereby authorize DuPage Plastic Surgery or its designated agent, to request on my/our behalf and to collect directly all public and private insurance coverage benefits due for services provided by Dupage Plastic Surgery. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to DuPage Plastics Surgery all checks for such payment.

Patient Initials:_________________

Release of Information

The undersigned authorized the release of all medical records related to my care to authorized representatives of DuPage Plastics Surgery, the patients third party payer, physicians, or other health care providers/venders. I authorize the use of patients record information for the purpose of review of quality and case management activities. Furthermore, I authorize the patient's third-party payer to release to DuPage Plastic Surgery, or its designated agents, all information pertaining to the patient's insurance benefits and status of claims submitted.

Patients Initials: ________________

Agreement of Payment

In consideration of Dupage Plastics Surgery providing me with services, the undersigned patient, spouse, guarantor and/or guardian agrees that each of the is responsible for payment to DuPage Plastics for all services provided. The undersigned also agrees to provide DuPage Plastics Surgery prompt notification of all changes in the insurance benefits and/or coverage, home address, telephone number and any other relevant information. I understand that I am responsible for the payment of services rendered through insurance, private pay, and all other types of coverage. I understand DuPage Plastics Surgery will submit claims as a service to me, but that this service does not relieve me of my financial obligation. I agree to pay all invoices upon receipt and that I may be refused further services from DuPage Plastics Surgery if I refuse to pay. Payment for services rendered are due within fifteen (15) days of the billing date. If said bill is not paid in full within thirty (30) days of the billing date, a penalty of one and one half (1 ½) percent (minimum $1.50) per month will be assessed on the unpaid balance. In the event that the service of a collection agency and/or attorney are utilized to collect a bill, the responsible party will be liable for all fees charged by the collection agency as well as any legal fees incurred by DuPage Plastics Surgery in connection with collection of the outstanding bill.
The undersigned certifies that he/she has read and understands the agreement. The undersigned also certifies that he/she in the patient or is duly authorized by the patient as patient's general agent to execute the above and accept the terms.
NOTE: a duplicate copy of this agreement and consent shall be considered the as the original.
Any credit or package needs to be redeemed with one year of purchase date
Patient Initials________________

I understand that office charges are payable on the day of service is rendered. I authorize Dr. Bull to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Bull and myself.
Patients or Guardian signature: ____ Date:______________________