MERIDIAN
PLASTIC SURGEONS

Meridian Plastic Surgery Center
for Laser & Cosmetic Surgery
the medical art of face & figure

History and Physical Data Sheet

MPSC sticker

Patient Name: _____
Last First MI

Date of birth: _____ Age _____ Height: _____ Weight: _____

Reason(s) for seeing physician: _____

In what surgical procedure are you interested?

___ Rhinoplasty (nose)	___ Forehead lift	___ Removal of moles or lesions	Breast: ___ Augmentation
___ Eyelids	___ Face or neck lift	___ Botox / Injectable filler	___ Reduction
___ Chin	___ Scar revision	___ Liposuction	___ Lift
___ Protruding ears	___ Skin resurfacing	___ Tummy tuck	___ Reconstruction

Other: _____

Have you consulted another doctor in regards to this type of surgical procedure? Yes No
If so, whom? _____

Family doctor / Internist: _____ Address: _____
Date of last physical exam: _____ May we notify him/her of your upcoming surgery? *Yes No*
If you are currently being treated by a psychiatrist or psychologist: *Yes No*
Name: _____ Phone number _____

Female Patients: OB/Gyn: _____ Contact # : _____-_____-_____
Date of last mammogram: _____ Where was it performed?: _____
Personal history of breast cancer? *Yes No* If yes: Date: _____ Side: Left Right
Bra size: _____ Other previous breast surgery: _____
Family history of breast cancer? *Yes No* If yes, Relationship: _____ Age: _____
Are you pregnant? *Yes No* Date of last menstrual period: _____
Past pregnancies #: _____ Number of live births #: _____ Did you breastfeed? *Yes No* # children breastfed? _____

Are you a smoker? *Yes No* # of packs a day _____ If stopped, when? _____
Use nicotine patch? *Yes No* Does anyone in your household smoke? *Yes No* *Other tobacco use:* _____
Do you take aspirin and/or baby aspirin, regularly? *Yes No* # Caffeinated drinks per day: _____
Ever taken Accutane? *Yes No* If stopped, when? _____ Alcohol use: Number of drinks per day _____

Have you ever been treated for or diagnosed with any of the following? Mark all that apply.

____ Rheumatic heart
____ Heart murmur
____ Angina / Chest pain
____ Heart attack
____ High blood pressure
____ Stroke
____ Cold sores / Fever blisters
____ Hepatitis / Jaundice
Type: A__ B__ C__
____ Hay fever / Nasal allergies
____ Lung / Chest problems
____ Asthma
____ Reflux
____ Ulcers
____ Lupus / Scleroderma
____ HIV / (AIDS)
____ Cancer: _____
____ Sleep Apnea
____ Migraines / TMJ
____ Depression / Anxiety
____ Psychiatric problems
____ Seizures / Convulsions
____ Bleeding disorder
____ MRSA
____ Anemia
____ Hypoglycemia
____ Excessive scarring
____ Staph infections
____ DVT, pulmonary embolas
____ Any eye problems / Glaucoma
____ Skin condition, infection, irritation or shingles
____Latex allergy
____Alcohol / Drug dependency
____ Recreational drugs: _____
_____
____ Diabetes
____ Kidney disease
____ Clotting disorder
____ History of immuno-suppressive drugs or chemotherapy past or present

Please note if you have:
____ Body Jewelry
____ Contact Lenses
____ Dentures - upper / lower

Do you have any other medical problems that have ***not*** been covered? List any additional information you think is or would be important for us to know about your medical/social history prior to surgery. _____
_____
_____
_____

Surgical History

Surgical history: _____

_____

Have you ever had any reaction (nausea) to local or general anesthesia (or a family history of problems)? *Yes* *No*

If yes, please describe: _____

Describe any complications you may have experienced: _____

_____

Current Medication & Vitamin/Supplement Record

Medication	Strength	Dosage	Frequency	Medication	Strength	Dosage	Frequency

Please list name, address and/or phone number of your pharmacy: _____

_____

Any known allergies? *Yes* *No* If yes, please list specific allergy and reaction: _____

_____

_____

***Confidential Record**: Information contained here **will not be released** unless you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in making decisions regarding your care.*

I authorize my physician and/or administrative and clinical staff to telephone or otherwise contact me (or responsible party) regarding appointments, treatment information, or any other details related to patient therapy and treatment.

Signature: _____ Date: _____

Do you realize every operation is followed by a period of healing before the tissues return to normal and a final result is apparent?

Yes No

*Do you understand that the objective of any cosmetic surgery is improvement in appearance, **not perfection?***

Yes No

DOS:	☐ **No Changes** ☐ **Updated**
Date:	M.D. Signature:

PERKINS | VAN NATTA
SADOVE | KELLEY
MERIDIAN PLASTIC SURGERY CENTER

Patient Information

Name: _____ Sex: M F
Last First MI

Home Address: _____
Street Apt. City State Zip Code

Phone: _____ _____ _____
Home Work Cell

E-Mail: _____ Social Security: _____

Birth Date: _____ Age: _____ Marital Status: S M D W Name of Spouse: _____

Referral Information

How were you referred? (Check all that apply)

☐ Patient: Name: _____ ☐ Friend: Name: _____

☐ Physician/Dentist: Name: _____ ☐ Nurse: Name: _____

☐ Newspaper ☐ Radio ☐ Yellow Pages ☐ Magazine: Name: _____

☐ Other Source: _____

Patient Employment Information

Employers Name: _____ Occupation: _____

Employer's Address: _____

Employer's Phone: _____

In case of emergency

Please list name, phone number, and relationship of person to contact:

Name: _____ Phone numbers: _____

Relationship to Patient: _____

Family Physician: _____ Address: _____ Phone #: _____

I recognize and accept full financial responsibility for all professional services rendered, regardless of the amounts covered by any applicable insurance coverage. In the event Perkins Van Natta Sadove Kelley or the Meridian Plastic Surgery Center is required to collect my account after default, I will be responsible for all attorney fees and cost of collection. If insurance is to be filed, I authorize release of medical information including photographs necessary to process any claim for services provided by Perkins Van Natta Sadove Kelley, and the Meridian Plastic Surgery Center. I further authorize an insurance company to pay benefits directly to Perkins Van Natta Sadove Kelley, and/or the Meridian Plastic Surgery Center.

Date: _____ _____
Signature of Patient/Responsible Party

_____
Relationship to Patient

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Patient Information

Insurance Information Part 1

As a courtesy to our patients, we will file your charges with your insurance company. However, the following information must be filled out completely for your procedures to be filed with your insurance carrier. Insurance deductibles which have not been met may require payment prior to your surgery. If this form is incomplete, you will be billed directly.

If your insurance requires that you have a referral from you Primary Care Physician, you must handle this by calling your Primary Care Physician. Please check to be sure that our Physicians and the Meridian Plastic Surgery Center are contracted with you insurance company. This is especially important if you have an HMO policy. Some Primary Care Physicians may refer you to Physicians not contracted with your insurance company, which poses a problem for you. If we are not a network provider for you, then check to see if you have out-of-network benefits. If so, out-of-network coverage is provided at a reduced rate. Refer to the phone number on your insurance card.

In order for our facility to give you the most information regarding you insurance benefits, you must supply us with a CURRENT insurance card including the billing address and phone number. Our medical assistants can help you with any question you may have if you call during our regular business hours, Monday through Friday, 9:00 a.m. to 5:00 p.m.

Primary Insurance Information

Primary Insurance _____

Address to Mail Claims _____

Phone _____ ID _____ Group _____

Member's Name _____

Member's SSN _____ Member's Birth Date _____

Member's Employer _____

Relationship to Member: Self Spouse Child Other _____

Secondary Insurance Information

Secondary Insurance _____

Address to Mail Claims _____

Phone _____ ID _____ Group _____

Member's Name _____

Member's SSN _____ Member's Birth Date _____

Member's Employer _____

Relationship to Member: Self Spouse Child Other _____

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MERIDIAN PLASTIC SURGERY CENTER

Patient Information

Insurance Information Part 2

If your procedure will require anesthesia, you need to know if your insurance requires you to use a specific group. The group that we use is North Side Anesthesiologist Service, LLC. Their phone number is (317) 802-6316.

Our facility uses Ameripath for any pathology testing. If you are having a procedure that is going to require pathology testing, you need to know if your insurance company will accept this lab. The phone number for the lab is 275-8112 or 1-866-635-1917.

It is our goal to help you obtain the maximum benefits from your insurance company, however, failure to follow through with verification of the above information could cause your coverage for these services to be denied and your benefits to be waived. **If you have a deductible that has not been met, you may be responsible for payment at the time of service.** Please keep in mind: ***Your insurance contract is between you and your insurance company, making it your responsibility to know your benefits.***

Please don't hesitate to call our office for any concerns you may have.

Ultimately, the patient is the only person who can effectively work out any disagreements related to reimbursement with the insurance company. The patient will be billed and expected to pay the portion of the total bill their insurance company does not pay. The only exceptions are in situations where a certain insurance plan has an agreement with the surgeon and/or the facility to accept the predetermined usual and customary allowance.

Note:
Because of the many changes occurring with insurance plans, it is very important for you to find out if your policy requires a second opinion, referral from your primary physician, or pre-certification for the procedure and/or an overnight observation. Failure to determine this information will result in a markedly reduced insurance payment.

I have read and understand the above stated insurance information.

Please initial: _____

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Patient Insurance Checklist

As patients approach surgery, they frequently need information regarding insurance benefits. As a courtesy to our patients, we would like to inform you of several things that are important to you when having any procedure that involves your insurance company. It is the patient's responsibility to check on the following:

1. *If your insurance requires that you have a referral from your Primary Care Physician (PCP), you must obtain the referral by calling your PCP. Please verify that both* ***physician(s) and Meridian Plastic Surgery Center*** *are contracted with your insurance company. This is especially important if you have an HMO policy. If we are not a network provider for you, please verify if you have out-of-network benefits.*

2. *If your procedure is going to require anesthesia at the Meridian Plastic Surgery Center, you will need to know if your insurance requires you to use a specific group. The group that we use is the North Side Anesthesiologist Service, LLC. Billing for North Side Anesthesia is handled by Susan J. Taylor Billing Service at phone number (317) 567-2179. You should ask to speak to Jennifer Walker at extension 106. Hours for the billing service are 8 am - 5 pm Monday through Thursday and 8 am - 2:30 pm on Friday.*

3. *The Meridian Plastic Surgery Center uses Ameripath of Indiana Laboratory for any pathology testing. If you are having procedures that will require pathology testing, you will need to verify that your insurance company will accept this lab. The telephone number for the Ameripath is (317) 275-8112 or 1-866-635-1917.*

In order for our facility to give you the most information regarding your insurance benefits, you must supply us with your **most current** insurance card(s) with the billing address(es) and phone number(s).

It is our goal to help you get the maximum benefits from your insurance company, but your failure to follow through with the above information could result in denial of coverage and cause your benefits to be waived. If you have a deductible that has not been met, you may be responsible for payment at the time of service. Please keep in mind that your insurance contract is between you and your insurance company, making it your responsibility to know your benefits.

Please be advised that the average waiting period for insurance benefit information is 7-14 working days. The average waiting period for predetermination for approval for small procedures is 8-12 weeks. The process can vary with different insurance companies. Please contact Cornella Scott with any questions or concerns you may have regarding precertification, predetermination, or insurance benefits. (317) 575-0336 ext 103.

I have been informed that Dr. Perkins and Dr. Van Natta are not in network health providers. Therefore, the amount covered by insurance for their services may be reduced due to their status as out of network health providers.

Please initial to confirm receipt of this information. _____

Patient Contact Authorization Form

Patient Name: _____

How may we contact you and/or leave a message? (Please circle)

HOME	YES	NO	FAX HOME	YES	NO
WORK	YES	NO	FAX WORK	YES	NO
CELL	YES	NO	EMAIL HOME	YES	NO
			EMAIL WORK	YES	NO

Can we send mail to you at: (Please circle)

HOME	YES	NO
WORK	YES	NO

To WHOM may we speak about your appointments, treatments, insurance, or billing?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: __ _____

Witness: _____ Date: __ _____

(This form is valid for one year unless revoked or changed by the patient.)

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HIPPA Acknowledgement

I hereby acknowledge that I have been made aware of the above-identified provider's Notice of Privacy Practices and that I may read a copy of it by my request.

Signature of Patient: _____

Printed Name: _____

Date: _____

Please return this page to the provider.