meridian
PLASTIC SURGERY

5002 Hwy. 39 N Bldg. C • Meridian, MS 39301 • 601-693-7742 • Fax 601-484-2465

PATIENT INFORMATION

Patient: _____
First Middle Last

Mailing Address: _____

_____
City State Zip

Social Security #: _____

Date of Birth: ____/____/____ **Age:** _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Spouse's Name: _____ **Date of Birth:** ____/____/____

Race: ❑ American Indian ❑ Asian ❑ African American ❑ Caucasian ❑ Other _____

Gender: ❑ Male ❑ Female

Primary Language: ❑ English ❑ Spanish ❑ Other

Ethnicity: ❑ *Not Hispanic/Latin* ❑ *Hispanic/Latin*

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Email Address: _____

Employer Name: _____

Employer Address: _____

_____
City State Zip

EMERGENCY CONTACT

In Case of Emergency Contact (Name) _____ (Relationship) _____ (Phone) _____

RESPONSIBLE PARTY INFORMATION

If patient is minor, parent or guardian is completing registration sheet

Name _____ **Social Security #** _____

Mailing Address _____

Date of Birth ____/____/____ **Sex:** Male or Female

Home Phone _____ **Cell Phone** _____ **Work Phone** _____ **Employer** _____

Employer Address _____
Street City State Zip

What prompted you to call for an appointment? (Please check all that apply):

❑ Physician Refferal ❑ Website ❑ Internet Search ❑ Facebook ❑ Instagram

❑ TV ❑ Family Member ❑ Friend ❑ Other: (Please Specify) _____

Referring Physician: _____ **Reason For Referral:** _____

I hereby consent to treatment for myself, my child, or the above named minor for who I accept responsibility. I authorize the release of my medical information to the Plastic Surgery Center of Meridian, LLC as needed for continuation of care and also the release of my medical information from the Plastic Surgery Center of Meridian, LLC to Meridian Plastic Surgery, PA as needed for the continuation of my medical treatment. The release of information to any insurance carrier or direct payment to Meridian Plastic Surgery, PA, Plastic Surgery Center of Meridian, LLC, or Plastic CRNA, LLC for any treatment or examination rendered is authorized. I hereby acknowledge and accept final responsibility for payment of charges for medical services rendered.

_____ _____ _____
Signature of patient or authorized person Relationship to patient Date

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Insurance Information

It is the patient's responsibility to notify the office of any and all insurance changes that may occur.

Primary Insurance:	Secondary Insurance:
Subscriber Name:	Subscriber Name:
Mailing Address:	Mailing Address:
Patients Relationship to Subscriber:	Patients Relationship to Subscriber:
Subscriber's Social Security Number:	Subscriber's Social Security Number:
Subscriber's Date of Birth:	Subscriber's Date of Birth:
Subscriber's Employer:	Subscriber's Employer:
ID#:	ID#:
Group:#:	Group#:

Authorization and Release of Information

According to office policy, test results or release of medical information will be provided to the patient only. If you would like your information to be made available to someone else, please specify below whom information may be released to other than yourself.

Name & Relationship: _____ Contact #: _____

Name & Relationship: _____ Contact #: _____

I understand that Meridian Plastic Surgery may release to my insurance company, managed care organization, State or Federal agencies, and third party administrators and/ or Workers Compensation or its agents any information needed to process my claims and/or determine benefits payable for related services. I also understand that MPS may utilize a fax machine to transmit any or all records pertaining to my medical care of insurance reimbursement. I understand that faxing my medical records may increase the risk of accidental disclosure. I also understand that it may be necessary for MPS to release all or part of my medical records to any consulting entity that may be involved in my care. I understand and acknowledge that MPS may use and disclose my records state and federal law for the purpose described in the Notice of Privacy Practices, in some cases without the requirement of authorization. Nonetheless, I authorize MPS to use and disclose my medical records for all necessary purposes under state and federal law and regulations.

Signature: _____

Third Party Laboratory

I understand that all lab testing and pathology services utilized while in the care of Meridian Plastic Surgery will be performed by a third party laboratory. I understand that I will receive a separate bill for those services rendered and I am responsible for payment of those services. MPS has agreed to transfer my insurance at the time of service so that rendered pathology services may be filed with my insurance company on my behalf.

Signature: _____

Notice of Privacy Practices:

I am aware or have been offered access to Meridian Plastic Surgery Notice of Privacy Practices explaining the uses and disclosures of my Health Information. These Privacy Notices are posted in the office and will be given upon request.

Signature: _____

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PATIENT PHOTOGRAPH RELEASE FORM

Patient Name: _____ Date of Birth: _____
Last First Middle

I hereby acknowledge that I have been advised that photographs may be taken of me or parts of my body before and after surgery. The photographs will be taken by one of the members of the Meridian Plastic Surgery medical staff.

Please initial acknowledgement of the following:

_____**Medical Care Only:** Photographs taken of me or parts of my body will be used solely for the purpose of my medical care with Meridian Plastic Surgery. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Meridian Plastic Surgery.

Please initial if you agree to use of photographs for the following purposes:

_____**Website:** Photographs taken of me or parts of my body can be used on the company's website as "Before and After" photos. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name or any other identifying marks at any time during any use or publication of these materials.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form,

_____
Signature (Patient or Parent/Guardian if Patient is under 18) Date

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PATIENT HISTORY

Name_____ Date of Birth: ____/____/____ Height _____ Weight _____

Reason for visit _____

Do you smoke? ❑ Yes ❑ No Alcoholic Beverage Use: ❑ Yes ❑ No

If Yes, _____ packs per day for _____ years. Number of drinks/beers per week _____

Do you use other tobacco products? ❑ Yes ❑ No

FAMILY HISTORY – Please circle if any blood relatives ever had problems with:

❑ Arthritis ❑ Bleeding Disorder ❑ COPD ❑ Heart Disease ❑ Kidney Disease ❑ Mental Disorder

❑ Asthma ❑ Cancer (Type) _____ ❑ Diabetes ❑ High Blood Pressure ❑ Melanoma ❑ Stroke

❑ None of the above apply

PAST MEDICAL HISTORY – Please circle if you ever had problems with:

❑ Anemia ❑ Cancer (Type)_____ ❑ Hepatitis ❑ Lung Disease ❑ Seizure Disorder ❑ TIA

❑ Arthritis ❑ COPD ❑ High Blood Pressure ❑ Melanoma ❑ Stroke

❑ Asthma ❑ Diabetes ❑ HIV ❑ Mental Disorder ❑ Thyroid Disease

❑ Bleeding Disorder ❑ Heart Disease ❑ Kidney Disease ❑ Mitral Valve Prolapse

❑ None of the above apply

Previous Surgeries and Year:_____

Major Illnesses:_____

Allergies: _____

List All Medications: _____

Have you had a mammogram in the past eighteen months? ❑ Yes ❑ No

If age 50-75, have you had a colorectal screening in the last 9 years? ❑ Yes ❑ No

If you have had any of the following please list date:

Breast Biopsy_____ Mastectomy _____ Radiation _____ Chemotherapy _____

Have you had the flu shot? ❑ Yes ❑ No

Have you had the pneumonia vaccine? ❑ Yes ❑ No

_____ _____ _____

Signature of patient or authorized person | Relationship to patient | Date