Meridian PLASTIC SURGERY

5002 Hwy 39 N Bldg.C • Meridian, MS 39301 • 601-693-7742 • Fax 601-693-7758

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 Sate 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 Referral** ☐ **Hospital** ☐ **Website** ☐ **Internet Search** ☐ **Billboard** ☐ **Newspaper** ☐ **TV**

☐ **Yellow Pages** ☐ **Magazine** ☐ **Radio** ☐ **Family Member** ☐ **Friend** ☐ **Other:** _____

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.

_____ **Date:** _____

Signature of patient or authorized person

PATIENT HISTORY

Name _____ Date of Birth ____/____/____ Height_____ Weight_____

Do you smoke? Yes No
If Yes, _____ packs per day for _____ years.

Alcoholic Beverage Use:
Number of drinks/beers per week _____

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

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

Anemia	Cancer (Type) _____	Hepatitis	Lung Disease	Seizure Disorder
Arthritis	COPD	High Blood Pressure	Melanoma	Stroke/TIA
Asthma	Diabetes	HIV	Mental Disorder	Thyroid Disease
Bleeding Disorder	Heart Disease	Kidney Disease	Mitral Valve Prolapse	

REVIEW OF SYSTEMS – Please circle if you have problems now or have had within the past year:

Ears/Nose/Mouth	Chest Pain	Heart	Neuro/Seizures	Skin
Endocrine	Gastrointestinal	Hematologic	Psychiatric	
Eyes	Genito/Urinary	Musculo/Skeletal	Respiratory	

Previous Surgeries and Year: _____

Major Illnesses: _____

Allergies: _____

List All Medications: _____

FOR WOMEN ONLY

Please identify any breast problems _____

Date of last Mammogram _____ If you have had any of the following please list date: Breast Biopsy _____
Mastectomy _____ Radiation _____ Chemotherapy _____

Form Completed by (if other than patient) _____ Relationship _____

_____ _____
Signature **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: _____