

PATIENT INFORMATION

Patient: _____
 First Middle Last

Gender: Male Female

Primary Language: English Spanish Other

Mailing Address: _____

Ethnicity: Not Hispanic/Latin Hispanic/Latin

City _____ State _____ Zip _____

Home Phone #: _____

Social Security #: _____

Work Phone #: _____

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

Cell Phone #: _____

Marital Status: Single Married Separated Divorced Widowed

Email Address: _____

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

Employer Name: _____

Race: American Indian Asian African American Caucasian Other _____

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 Referral
 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



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

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: _____

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 two 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 _____



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