

# 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?***

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Rhinoplasty (nose) | <input type="checkbox"/> Forehead lift     | <input type="checkbox"/> Removal of moles or lesions | Breast: <input type="checkbox"/> Augmentation |
| <input type="checkbox"/> Eyelids            | <input type="checkbox"/> Face or neck lift | <input type="checkbox"/> Botox / Injectable filler   | <input type="checkbox"/> Reduction            |
| <input type="checkbox"/> Chin               | <input type="checkbox"/> Scar revision     | <input type="checkbox"/> Liposuction                 | <input type="checkbox"/> Lift                 |
| <input type="checkbox"/> Protruding ears    | <input type="checkbox"/> Skin resurfacing  | <input type="checkbox"/> Tummy tuck                  | <input type="checkbox"/> 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.***

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Rheumatic heart   | <input type="checkbox"/> Reflux                 | <input type="checkbox"/> Anemia  | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> Heart murmur  | <input type="checkbox"/> Ulcers                 | <input type="checkbox"/> Hypoglycemia                                      | <input type="checkbox"/> Kidney disease  |
| <input type="checkbox"/> Angina / Chest pain   | <input type="checkbox"/> Lupus / Scleroderma    | <input type="checkbox"/> Excessive scarring                                | <input type="checkbox"/> Clotting disorder   |
| <input type="checkbox"/> Heart attack  | <input type="checkbox"/> HIV / (AIDS)           | <input type="checkbox"/> Staph infections                                  | <input type="checkbox"/> History of immuno-suppressive drugs or chemotherapy past or present |
| <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Cancer: _____          | <input type="checkbox"/> DVT, pulmonary embolas                            |  |
| <input type="checkbox"/> Stroke  | <input type="checkbox"/> Sleep Apnea            | <input type="checkbox"/> Any eye problems / Glaucoma                       |  |
| <input type="checkbox"/> Cold sores / Fever blisters                                   | <input type="checkbox"/> Migraines / TMJ        | <input type="checkbox"/> Skin condition, infection, irritation or shingles |  |
| <input type="checkbox"/> Hepatitis / Jaundice  | <input type="checkbox"/> Depression / Anxiety   | <input type="checkbox"/> Latex allergy                                     | Please note if you have:   |
| Type: A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> | <input type="checkbox"/> Psychiatric problems   | <input type="checkbox"/> Alcohol / Drug dependency                         | <input type="checkbox"/> Body Jewelry  |
| <input type="checkbox"/> Hay fever / Nasal allergies                                   | <input type="checkbox"/> Seizures / Convulsions | <input type="checkbox"/> Recreational drugs: _____                         | <input type="checkbox"/> Contact Lenses  |
| <input type="checkbox"/> Lung / Chest problems   | <input type="checkbox"/> Bleeding disorder      |  | <input type="checkbox"/> Dentures - upper / lower  |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> MRSA                   |  |  |

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:		<input type="checkbox"/> No Changes <input type="checkbox"/> Updated
Date:	M.D. Signature:	



# 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 Meridian Plastic Surgeons 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 Meridian Plastic Surgeons and the Meridian Plastic Surgery Center. I further authorize an insurance company to pay benefits directly to Meridian Plastic Surgeons and/or the Meridian Plastic Surgery Center.*

Date: \_\_\_\_\_

\_\_\_\_\_  
 Signature of Patient/Responsible Party

\_\_\_\_\_  
 Relationship to Patient



## Patient Insurance Information

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 your 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 your 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 your 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 \_\_\_\_\_



## 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. Meridian Plastic Surgery Center utilizes North Side Anesthesiologist Service, LLC. Billing for North Side Anesthesia is handled by Susan J. Taylor Billing Service. You should ask to speak to Melissa Shank at 317-614-9812. Hours for the billing service are 8 am - 5 pm Monday through 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.

The average waiting period for predetermination for approval for procedures is 6-8 weeks. The process can vary with different insurance companies. Please contact Brenda Hatcher (317) 663-7217 with any questions or concerns you may have regarding precertification, predetermination, or insurance benefits.

*I have been informed that Dr. Perkins and Dr. Van Natta are not in network health providers. Dr. Sadove, Dr. Kelley, and the fellow participate in Anthem insurance only.*

*Please initial to confirm receipt of this information.* \_\_\_\_\_

*Date:* \_\_\_\_\_



## 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

Fax Work:    yes    no

Work:    yes    no

Email Home:    yes    no

Email Work:    yes    no

Cell:    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.)



### FMLA/Disability Insurance Acknowledgment

1. Will you be using FMLA or Disability Insurance after your procedure? Yes or No
2. Do you have your paperwork from your employer/insurance company with you today? Yes or No

**\*\*\*\*BE ADVISED THERE IS A THREE WEEK TURN AROUND TIME ON ALL FMLA AND DISABILITY PAPERWORK FROM THE DAY THE PAPERWORK REQUEST IS RECEIVED. NO EXCEPTIONS\*\*\*\***

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient

### HIPPA Acknowledgment

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.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Printed Name

Please return this page to the provider.

**Directions to:**

170 West 106th Street

Indianapolis, IN 46290

For more information: (317) 575-0330 or  
800-345-1962

**FROM THE NORTH**

Traveling South on Meridian Street (US 31) stay in the right lane, exit right (west) at the 106th Street exit. Our office is on the right on the North side of the street.

**FROM THE SOUTH**

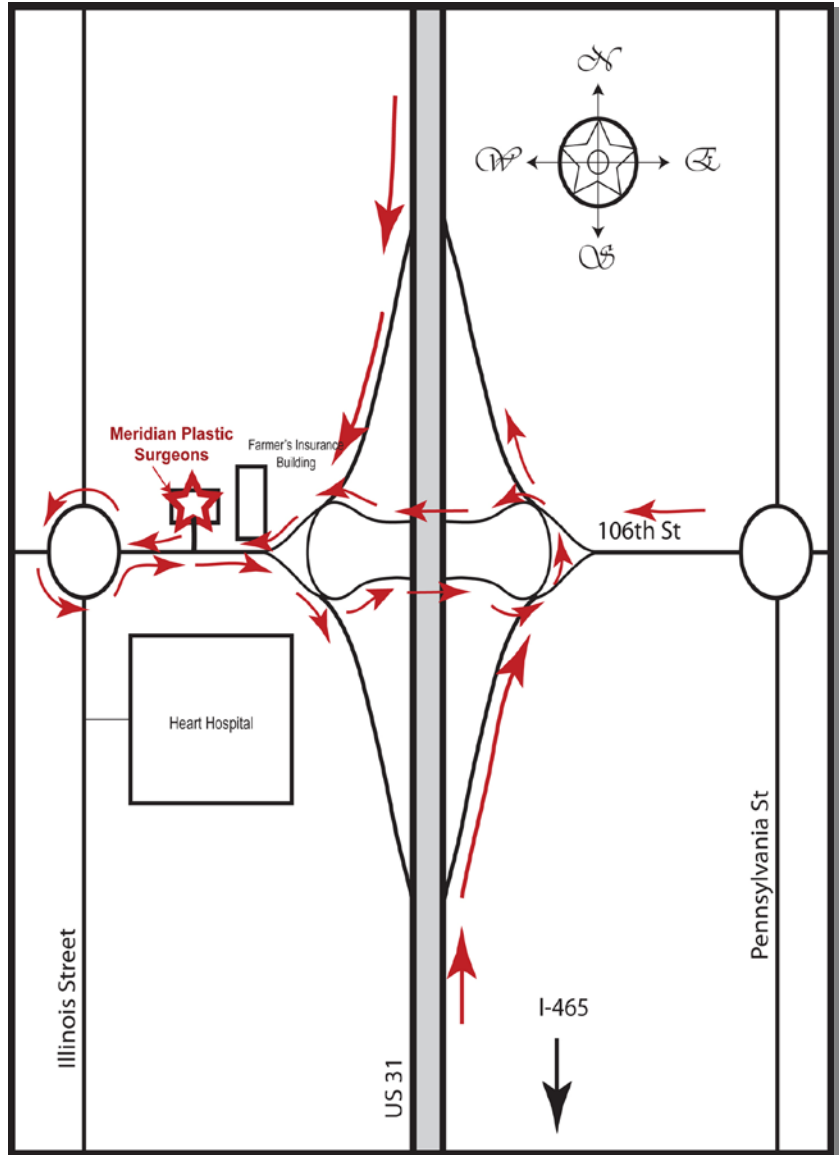
Traveling north on Meridian Street (US 31), stay in the furthest right lane and exit on the 106<sup>th</sup> Street exit. From the exit ramp, turn left (west) onto 106<sup>th</sup> street. Stay in the right lane on the roundabout and Meridian Plastic Surgery Center is on the right (north) side of the street.

**FROM THE EAST**

Traveling from the East on I-465 North, take the Meridian Street exit (US 31) and exit right (north). Stay in the furthest right lane and exit on the 106<sup>th</sup> Street exit. From the exit ramp, turn left (west) onto 106<sup>th</sup> street. Stay in the right lane on the roundabout and Meridian Plastic Surgery Center is on the right (north) side of the street.

**FROM THE WEST**

Traveling from the West on I-465 North, take the Meridian Street exit (US 31) and exit right (north). Stay in the furthest right lane and exit on the 106<sup>th</sup> Street exit. From the exit ramp, turn left (west) onto 106<sup>th</sup> Street. Stay in the right lane on the roundabout and Meridian Plastic Surgery Center is on the right (north) side of the street.



\*Please note that upon exiting Meridian Plastic Surgery Center, you cannot make a left (East) onto 106<sup>th</sup> Street. You must exit right (West), go around the roundabout at Illinois and exit onto 106<sup>th</sup> Street east toward US 31 from there.





## Mission Statement

Through our collaborative effort, the mission of Meridian Plastic Surgeons is to:

*Provide superior patient care, utilizing the clinical and surgical experiences of our staff. Bring energy, enthusiasm, care, and commitment to our patients every day.*

*We strive for distinction through continuing education in cosmetic and reconstructive surgery, ensuring quality care by balancing technical expertise with warmth and dedication. We believe in a well-informed patient. By practicing the highest ethical standards, we will better serve our patients and gain their trust.*

*We continuously advance to provide safe, high quality care to our patients in a confidential, convenient setting: which is devoted solely to plastic surgery. Patient satisfaction is our final reward. We are committed to excellence.*

**Dr. Stephen Perkins**

**Dr. Bruce Van Natta**

**Dr. A. Michael Sadove**

**Dr. Christine Kelley**

**The Staff at Meridian Plastic Surgeons and the Meridian Plastic Surgery Center**