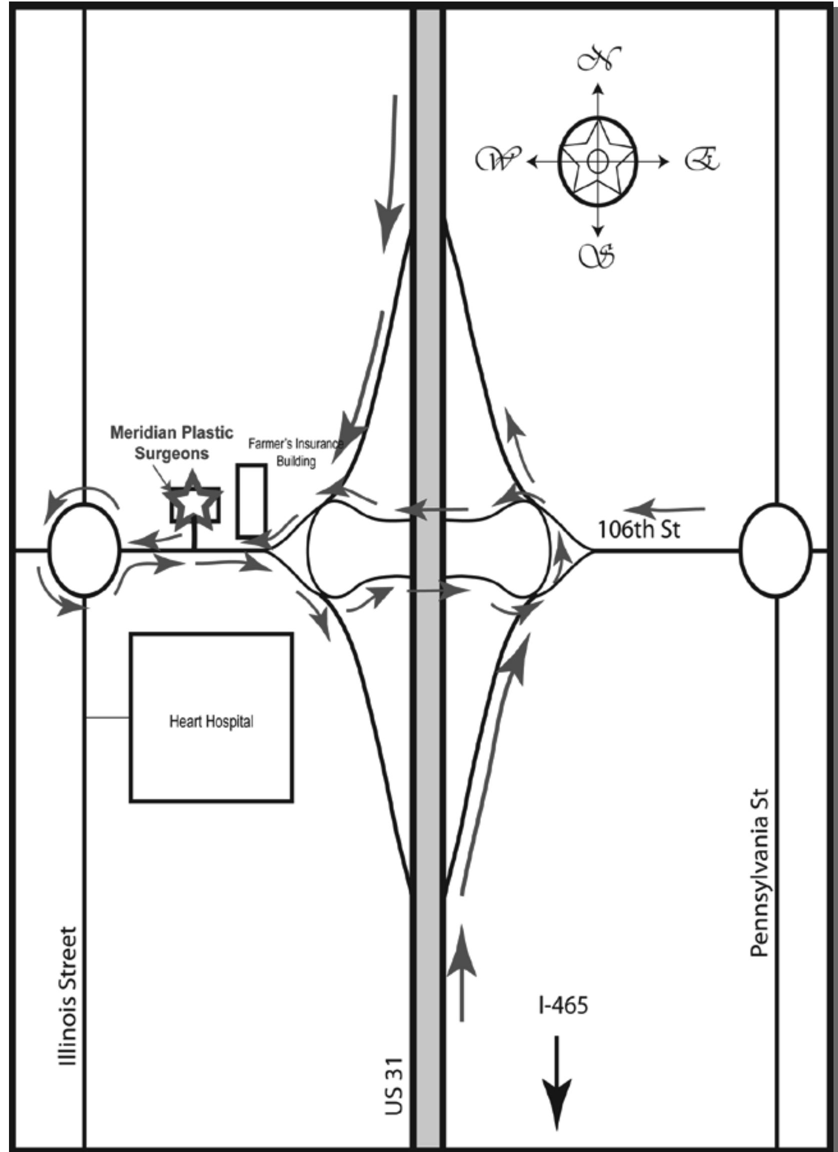
MERIDIAN
PLASTIC SURGEONS

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 106th Street exit. From the exit ramp, turn left (west) onto 106th 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 106th Street exit. From the exit ramp, turn left (west) onto 106th 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 106th Street exit. From the exit ramp, turn left (west) onto 106th 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 106th Street. You must exit right (West), go around the roundabout at Illinois and exit onto 106th Street east toward US 31 from there.

MERIDIAN PLASTIC SURGEONS

Meridian Plastic Surgery Center for Laser & Cosmetic Surgery

the medical art of face & figure™

History and Physical Data Sheet

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:

Revised 2-16-15

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 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 ____________

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.)

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.

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