Artistic Plastic Surgery
Garth Meldrum MD

Patient Information as of _____ (enter today's date)
Please print legibly and fill in all fields.

Patient's Name _____
Last *First* *Middle*

Address _____
Street & Apt. # *City* *State* *Zip*

Home Phone _____ Cell Phone _____ Other _____

Email _____ Driver's License # (and state) _____

Contact Restrictions? ☐ Yes ☐ No If so, what? _____

Sex ☐ Male ☐ Female Birthdate _____/_____/_____ Age _____ SS # _____-_____-_____

Marital Status ☐ Single ☐ Married to: _____ ☐ Other: _____

Primary Care Physician _____ Referring Physician _____

Patient's Employer _____ Occupation _____

Work Phone _____ Is it okay to call you at work? ☐ Yes ☐ No

Address _____
Street & Apt. # *City* *State* *Zip*

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt. # *City* *State* *Zip*

Primary Insurance Company _____ Insurance Phone _____

Policy # _____ Group # _____ Employer _____ Referral Required? ☐ No ☐ Yes

Insured Name _____ DOB _____ Copay? ☐ No ☐ Yes, $ _____

Secondary Insurance Company _____ Insurance Phone _____

Policy # _____ Group # _____ Employer _____ Referral Required? ☐ No ☐ Yes

Insured Name _____ DOB _____ Copay? ☐ No ☐ Yes, $ _____

How did you hear about us? _____

*Authorization: I hereby authorize my insurance benefits to be paid directly to **Garth Meldrum, MD** and I authorize release of any information required by my insurance company. I hereby agree to pay any charges that exceed or that are not covered by insurance. I understand that if I have an HMO and **Garth Meldrum, MD** does not receive a referral, I will be financially responsible for all charges. If this account is referred to an attorney or collection agency for collection, I agree to pay all collection costs, including reasonable attorney fees, whether or not an action is filed. In this event, the prevailing party in such proceeding shall be entitled to recover a reasonable attorney fee, or an appeal thereof, in addition to the costs and disbursements allowed by law.*

Signature _____ **Date** _____

ARTISTIC PLASTIC SURGERY
GARTH MELDRUM MD

ACKNOWLEDGEMENT AND CONSENT

I understand that:
Garth Meldrum, MD LCC (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice my use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or other who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and reimburse for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notices of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting or reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

I understand that if someone other than I is the insured, I authorize communication between that person and the above noted provider. I also authorize communication between this office and my spouse relating to insurance and account issues. If I am under the age of 18 and my parents are providing my health insurance, I authorize communication between them and the above noted provider.

We may contact you by phone, mail, or leave a message on your answering machine to provide and appointment reminder.

By signing below, I agree that I have reviewed and understand the information above and that I can request a copy of the full Notice of Privacy Practices.

By:	Date:
(Patient)	

By:	Date:
(Patient Representative)	
Description of Authority:	

ARTISTIC PLASTIC SURGERY
GARTH MELDRUM MD

Alternate Contact Information &
Release of Information Consent Form

Patient Name: _____ Patient DOB: _____

Part I Alternate Contact Information Consent

Garth Meldrum MD LLC has Consent to:

Y N Leave medical information on my home answering machine

Y N Contact me at my place of employment.

Y N Leave medical information on voice mail at my place of employment.

Y N Email me regarding special events

(Messages will not be left on answering machines or voice mail if the recorded greeting does not include confirmation of your name or phone number.)

Part II Release of information consent

I authorize Garth Meldrum MD LLC to discuss **ANY** information regarding my medical care with below-mentioned persons: (Only list names of persons you are authorizing us to discuss **ANY** information with.)

Name: _____Relationship:_____

Phone Number: _____

Name: _____Relationship:_____

Phone Number: _____

Use additional space on back of this form if needed.

_____ _____

Patient or Patient Guardian Signature **Date**

_____

Print Name/Relationship to Patient

This Authorization is valid until revoked by the patient orally or in writing at any time.

(Consent Termination Date: _____**)**

Medical History Form

Patient's Name: Birth Date: Date:

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?
IF YES, PLEASE ANSWER THE QUESTION TO THE RIGHT OF THE "YES"

Condition:	No	Yes	Explanation:
Medication Allergies			Which Medications:
Are You Allergic To Latex?			
Cancer			Location:
History of cold sores			
Tuberculosis			Year of illness:
Emphysema			Current Treatments:
Other Lung Problems			Describe:
Rheumatic Fever			Age of illness:
Asthma			Does it interfere with activity?
Heart Murmur			
Do you have a Pacemaker or Defibrillator?			Maintenance Physician:
Do you have a Cardiologist?			Who?
Heart Attack? Stents? Stroke?			Which one and when?
Abnormal Hearing Conditions			Describe:
High Blood Pressure			How many years?
Abnormal Bleeding or Clotting?			Describe:
Blood Transfusion within the last 10 years			Date of transfusion:
HIV			
Are you taking Aspirin?			Dosage? Reason?
Are you taking Coumadin?			Dosage? Reason?
Do you have a history of MRSA?			
Kidney Problems			Describe?
Bladder Infection			Are you currently on medication?
Abnormal Liver			Describe?
Abnormal Gall Bladder			If removed what year?
Rectal Bleeding			
Hepatitis (Yellow Jaundice)			Year…….. Type if known:
Diabetes			Age of onset:
Epilepsy			Age of onset:
Thick or raised scarring?			Describe:
IV Drug Use			
Are you currently pregnant?			Expected date of delivery?
Do you smoke or use other nicotine products, including E-cig/Vape?			Type, quantity and how long?
Do you drink Alcoholic Beverages?			Type of drink…… Number per day
Other Medical Problems:			
Previous Surgeries:			Please list Age & Type:
Current Medications Including Non Prescription Drugs, Vitamins and Herbs:			Please list:

Family History: Please mark "yes" if you have family members who have had one of the following conditions:

Family History:	No:	Yes:	Relationship:	
High Blood Pressure				
Diabetes				
Epilepsy				
Heart Disease				
Cancer				Type of Cancer: