Sando & Aker My Plastic Surgery Group, 11450 N Meridian St., Ste 225, Carmel, IN 46032
317-848-5512 - *www.myplasticsurgerygroup.com* - *info@sandoaker.com*

Today's Date:_____

Patient Legal Name: (first)_____ (m.i.)_____ (last)_____

Address _____ City _____ State_____ Zip _____

Cell Phone: (_____)_____ Home Phone: (_____)_____ Office Phone: (_____)_____

Circle your preferred phone: Cell Phone | Home Phone | Office Phone

E-mail Address_____ _____

May we send correspondence: To the address above? Y N | Via Text Message? Y N | Via Email? Y N

Sex: male female Age_____ Birth Date _____ /_____ /_____ Marital Status:_____ _____

Specific Reason for Visit:_____

Primary Care Physician: (first & last name)_____ Ph#_____

Referring Physician: (first & last name)_____ Ph#_____

Employer:_____Occupation:_____

Pharmacy Name: _____ Ph#_____

How did you hear about My Plastic Surgery Group? (Please check all that apply)

□ Family Member (name)_____ □ Medical/Insurance Guide_____

□ Friend (name)_____ □ Internet (site)_____

□ Day Spa/Hair Salon_____ □ Physician (name)_____

□ Magazine:_____ _____ □ Seminar:_____

□ Patient (name):_____ □ Yellow Pages:_____

□ Newspaper (name):_____ □ Other:_____

In the event of an emergency, whom should we contact?

Name_____ Relationship _____

Address _____ City _____ State _____ Zip _____

Cell Phone: (_____)_____ Home Phone: (_____)_____ Office Phone: (_____)_____

I, _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, I'm accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him**.**

"To the best of my knowledge, the information I have provided above and on my history and physical, regarding my medications, past medical history, allergies and smoking history is accurate, complete and honest. I understand that failure to completely disclose this information may be detrimental to my condition and treatment and I accept full responsibility for any omissions." I understand that photography is a necessary part of planning and evaluating cosmetic and reconstructive surgery. I authorize the taking of photographs at the direction of my surgeon and under such conditions as may be approved by him. These photographs will be used solely for documentation purposes and will be kept confidential.

Patient Signature _____ Date _____

Relationship: (circle one) PATIENT SPOUSE PARENT GUARDIAN

Billing of Insurance

I agree to provide current and complete information so that charges may be billed to my insurance company. I authorize the release of all medical information necessary to process the claim. I understand that I will be responsible for any charge not covered by insurance (including deductibles and co-pays), or in the event there is no insurance coverage. I understand that I am responsible for any balance after insurance reimbursement except for Workman's Compensation cases.

Patient Signature _____ Date _____

Date: _____ **HISTORY AND PHYSICAL** **MY PLASTIC SURGERY GROUP**

Patient Name: _____ Nickname: _____

Height _____ Weight _____ Date of Birth _____ Age _____

List any Prescription Medications: _____

List any Herbals/Vitamins/Over the counter Medications: _____

ALLERGIES: _____

List ANY prior surgeries and the year: _____

List ANY adverse reaction to anesthesia: _____

Family History: (Please check ALL that apply) ☐ Anesthesia Problems ☐ Heart Problems ☐ Sugar/Diabetes
☐ Clotting disorders/Pulmonary Emboli/Deep Vein Thrombosis
☐ Breast Cancer/Disease Relationship:_____

Patient History: (Please check ALL that apply) ☐ Weight Loss ☐ Alcohol Use ☐ Tobacco Use _____
☐ Anesthesia Problems ☐ Heart Problems, including stint or pacemaker ☐ Sugar/Diabetes
☐MRSA ☐Breast Cancer/Disease
☐Clotting disorders/Pulmonary Emboli/Deep Vein Thrombosis
☐ Pregnancies How many? _____ ☐ Breast Fed How long? _____

BREASTS: ☐ Mammogram: Where_____ When _____
☐ Lumps Current Bra Size _____ Desire _____

HEAD & NECK: ☐ Headaches ☐ Sinus Problems ☐Vision (dry eyes/glaucoma)

LUNGS & CIRCULATION: ☐ Prior Pneumonia ☐ Bronchitis ☐ Asthma ☐ Chest Pain ☐ Heart Attack/Angina
☐ Blood Clots ☐ High Blood Pressure ☐ Murmurs ☐ Stroke/TIA ☐ Arrhythmias

BOWEL/KIDNEY/BLADDER: ☐ Acid Reflux ☐ Ulcers ☐ Irregularity ☐ Dribbling/Incontinence
☐ Bladder/Kidney Infections ☐ Stones

NERVOUS SYSTEM: ☐ Migraines ☐ Fainting ☐ Seizures ☐ Weakness ☐ Numbness ☐ Fibromyalgia ☐ Pain

HEMATOLOGIC: ☐ Daily Aspirin, Motrin, Aleve, Advil or Ibuprofen? ☐ Bruise or Bleed Easily

CONNECTIVE TISSUE: ☐ Skin Rashes ☐ Itching ☐ Cold Sores ☐ Acne ☐ Autoimmune ☐ Arthritis

******Patient Signature: _____ Date:_____**

PHYSICIAN USE ONLY

Physical Exam:

HEENT _____
CHEST _____
HEART _____
ABDOMEN _____
GU _____
EXT _____
NEURO_____

Breast Exam:

Est. Breast Volume R_____ L_____
Sternal to Nipple R_____ L_____
Breast Width R_____ L_____
Areola Diameter R_____ L_____
IMF to Nipple R_____ L_____
Pinch Thickness R_____ L_____
Implant Range R_____ L_____
Implant Style R_____ L_____

NOTES:

Physician / Staff Signature: _____ Date:_____

Credit Card Charge Authorization & Refund Policy Agreement

My Plastic Surgery Group is committed to excellent care and patient experience. Due to the popularity of our elite services, we have implemented policies to make certain all patients are given quality service. Please allow 24 hours' notice for cancellation or rescheduling to avoid 100% charge. Should you arrive late for your appointment, your service will be modified to maximize your remaining time to honor other scheduled appointments.

We provide appointment confirmations via email, text or phone call. However, this is not guaranteed. It remains patient's responsibility to remember the appointment dates and times to avoid late arrivals, missed appointments and help us service our patients better by providing enough notice to avoid the cancellation fees.

We request the courtesy of a 24-hour notice in the event an appointment must be cancelled or rescheduled. A $55.00 no-show fee for a consultation with the doctor or an aesthetic appointment will be applied in the event the 24-hour cancellation notice is not given. Appointments scheduled same day of service will be assessed a no-show fee should a cancellation become necessary. A **48-hour** notice is required for any spa packages and multiple treatments lasting more than 2 hours. Insufficient notice to cancel are subject to charges up to full service value. All no-show reservations will be assessed a charge at full value of services. For treatments that are pre-paid (including packages) the treatment will be forfeited without a 24-hour cancellation. Lastly, there are no refunds for products or services after purchase. Thank you for your cooperation.

I, _____, (printed name) hereby authorize My Plastic Surgery Group to charge my credit card in the amount of $55.00 for a missed treatment or appointment. I have read this entire agreement and understand that I will be held fully responsible for its terms and charges. I agree not to chargeback My Plastic Surgery Group if I receive the services that are entitled to me and guidelines are followed for my rescheduling and cancellation of appointments.

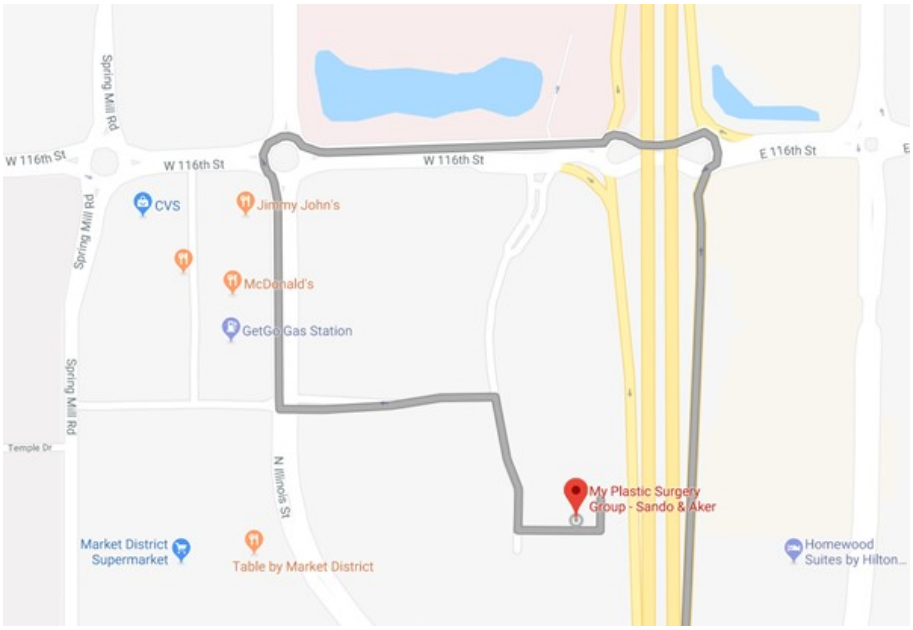
I understand that if I dispute services or products paid by credit card, any confidentiality rights under HIPPA regarding communications by My Plastic Surgery Group with the credit card company are hereby voluntarily waived.

Patient Signature:_____ Date:_____

MY PLASTIC SURGERY GROUP

SANDO • AKER

11450 North Meridian Street, Suite 225
Carmel, IN 46032



IMPORTANT:

Do not rely on GPS or Apple Maps for directions. Some GPS systems have not been updated and may not recognize you cannot access our building from Meridian.

The entrance to our office is on the Southside of the building, enter the doors and use either the elevator or stairs where you will find us on the 2nd Floor, Suite 225.

If you have not been to the office before, please give yourself time to find us and complete any paperwork needed once you get here.

Feel free to call us if you get lost!

317 848 5512

Follow Meridian Street to 116th Street.
Turn West on 116th Street & continue to the roundabout.
At the round about, take the 3rd right to head South on Illinois Street.
Take your 1st Left (East) into Fidelity Plaza.
At stop sign, take a Right (South) on Meridian Street Frontage Road.
Our building is located on the Left.
Our entrance is on the southside of the building opposite of Stock Yards Bank.
Enter through doors and take the stairs or elevator 2nd floor, suite 225.