Southlake Plastic Surgery, P.A.
Mark E. Mason, M.D.
Dinah Wan, M.D.

1. Patient Information:

____
Last Name First Name MI

____
Address

____
City State Zip

Sex ☐ Female ☐ Male

Social Security ______-_____-______

Birth Date ______/______/______

Home Phone ( ) ____________________ ☐ Check

Cell Phone ( ) ____________________ ☐ Preferred

Work Phone ( ) ____________________ ☐ Contact

Email ____________________________ ☐

Marital Status ☐ S ☐ M ☐ D ☐ W

Spouse Name: ____________________________

Emergency Contact Name & Telephone Number:

____

Primary Care Doctor: ____________________________

Primary Care Doctor Phone ( ) ____________________

2. Consultation:

Reason for consultation: ____________________________

How did you hear of us?

☐ Friend/Word of Mouth ____________________________

☐ Magazine/Newspaper ____________________________

☐ Internet/Website ☐ Phone Book

☐ Doctor ____________________________

☐ Other ____________________________

Please indicate if you want correspondence from our office sent in a sealed envelope marked "Confidential".

______ Yes ______ No

4. Insurance Information:

Primary Insurance ____________________________

Address ____________________________

Insured's Name ____________________________

Insured's Birth Date ______/______/______

Insured's Employer ____________________________

Insured's Social Security ______-______-______

Policy # ____________________________

Group # ____________________________

Secondary Insurance ____________________________

Address ____________________________

5. Consent for Treatment:

I agree to a medical consultation by Mark E. Mason, M.D. or Dinah Wan, M.D. including examination, treatment, photographs, and any diagnostic procedures as may be necessary.

I hereby authorize payment of medical benefits to be paid directly to Southlake Plastic Surgery, P.A. for services rendered. I furthermore understand that I am personally responsible for any charges incurred by me, regardless of insurance coverage. My signature affirms all the statements made above.

______________________________ ______________
Signature Date

Name ____________________

5. Health History: Age ________ Height ________ Weight ________

List any allergies you have to medications, foods, etc: Do you have a Latex Allergy? ☐ Yes ☐ No

____

Do you smoke? ☐ Yes ☐ No
If yes, how many packs a day? ________________

Do you drink alcohol? ☐ Yes ☐ No
If yes, how many drinks per week? ________________

Do you use or have you used recreational drugs? ☐ Yes ☐ No
List major illnesses and dates ____

List previous surgeries and dates ____

List previous cosmetic procedures and dates ____

List any medications you are taking including non-prescription drugs, vitamins, or herbal supplements ________________

Pharmacy Name & Telephone ____

Has any blood relative ever had the following?

Breast cancer	Yes	No	Melanoma	Yes	No	Stroke	Yes	No
High blood pressure	Yes	No	Heart disease	Yes	No	Diabetes	Yes	No
Kidney disease	Yes	No	Depression	Yes	No	Blood clots	Yes	No

Do you have now or have you had within the past year:

Weight change	Yes	No	Dry eyes	Yes	No	Chronic cough	Yes	No
Chest pain	Yes	No	Abnormal heart beat	Yes	No	Jaundice	Yes	No
Skin rash	Yes	No	Depression	Yes	No	Easy bleeding	Yes	No
Chronic diarrhea	Yes	No	Swollen lymph nodes	Yes	No	Easy bruising	Yes	No
Joint or muscle pain	Yes	No	Swollen feet/ankles	Yes	No	Seizures	Yes	No

Have you had any of the following?

Heart disease	Yes	No	AIDS or HIV+	Yes	No	Stroke	Yes	No
High blood pressure	Yes	No	Arthritis	Yes	No	Hepatitis	Yes	No
Mitral valve prolapse	Yes	No	Rheumatic Fever	Yes	No	Asthma	Yes	No
Stomach ulcer	Yes	No	Tuberculosis	Yes	No	Glaucoma	Yes	No
Kidney disease	Yes	No	Diabetes	Yes	No	Bleeding tendency	Yes	No
Thyroid disease	Yes	No	Cancer	Yes	No	Radiation treatment	Yes	No

6. Women Only:

Age period began ________ Did you breast feed? Yes No

Number of pregnancies ________ Do you do regular breast examinations? Yes No

Number of children ________ Breast lump or discharge? Yes No

Date of last mammogram ________ Current Bra Size ________

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

____
Signature of patient or parent if minor Date