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