

Southlake Plastic Surgery, P.A.
Mark E. Mason, M.D., F.A.C.S.

1. Patient Information:

Last Name First Name MI

Address

City State Zip

Primary Care Doctor: _____

Primary Care Doctor Phone () _____

Sex Female Social Security _____ - _____ - _____
 Male Marital Status S M D

Age _____ Birth Date ____ / ____ / ____

Spouse Name: _____

Home Phone () _____ Check

Cell Phone () _____ Preferred

Work Phone () _____ Contact

By checking the below box I give Southlake Plastic Surgery permission to contact me via email with future communications or scheduling information.

Email _____

3. Responsible Party:

Check here if same as patient information

If not, please complete the following:

Last Name First Name MI

Birth Date ____ / ____ / ____ Social Security _____ - _____ - _____

Home Phone () _____

Work Phone () _____

Driver's License # _____

Employer _____

Relation to patient _____

2. Insurance Information:

Primary Insurance _____

Address _____

Insured's Name _____

Insured's Birth Date ____ / ____ / ____

Insured's Employer _____

Insured's Social Security _____ - _____ - _____

Policy # _____

Group # _____

Secondary Insurance _____

Address _____

4. Consultation:

Reason for consultation: _____

How did you hear of us? Phone Book

Friend/Word of Mouth _____

Magazine/Newspaper _____

Internet/Website _____

Doctor _____

Other _____

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

Yes No

5. Consent for Treatment:

I agree to a medical consultation by Mark E. Mason, M.D., F.A.C.S. 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 _____

6. 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

7. 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 _____