Las Colinas Centre for Plastic Surgery

7433 Las Colinas Blvd. • Irving, Texas 75063

DATE ____________________________

MICHAEL R. WHETSTONE, M.D.

PATIENT'S FULL NAME ____

ADDRESS ____

CITY/STATE/ZIP ____

❑ HOME PH ______________ ❑ WORK PH ______________ ❑ CELL PH ______________

Please Check Preferred Contact Number

EMAIL ADDRESS ____

BIRTHDATE ____/____/____ AGE ______ SEX ____ MARITAL STATUS ________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ______________________________

MAY WE HAVE YOUR PERMISSION TO EMAIL YOU UPCOMING PRACTICE INFO AND EVENTS? ❑ YES ❑ NO

MAY WE CONFIRM YOUR APPOINTMENTS BY TEXT? ❑ YES ❑ NO

PATIENT'S OCCUPATION ____

EMPLOYER ____

EMERGENCY CONTACT ____________________________ PHONE # ____________________

FAMILY PHYSICIAN ____________________________ PHONE # ____________________

Please check if you are interested in receiving information about:

- ❑ Fillers
- ❑ Botox Cosmetic
- ❑ Laser Resurfacing
- ❑ Chemical Peels
- ❑ Dermaplaning
- ❑ Skin Tightening
- ❑ Microdermabrasion
- ❑ Laser Hair Removal
- ❑ Spider Vein Therapy
- ❑ Facials
- ❑ Waxing
- ❑ Genesis Laser
- ❑ SkinCeuticals
- ❑ Image
- ❑ Photo Facial

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical and personal information necessary for my care and treatment. I authorize the release of any medical information necessary to process insurance claim(s). I authorize payment of medical benefits to the physician for services rendered, and further understand that I am responsible for coinsurance, deductibles, and co-payment amounts as determined by my insurance carrier. Patients who carry Health Care Insurance should remember that professional services are rendered and charged to the patient and not the Insurance Company. We will submit charges to your Insurance Company as a courtesy; however, payment of your account is your responsibility.

______________________________ ______________________________

DATE SIGNATURE

TURN OVER AND PLEASE FILL OUT INFORMATION ON THE BACK OF THIS FORM

MEDICAL INFORMATION

NAME OF PATIENT ____

REASON FOR CONSULTATION ____

HEIGHT ________________________________ WEIGHT _____________________________

SERIOUS ILLNESSES (Include Dates) ____

SERIOUS INJURIES ____

PREVIOUS SURGERIES

____

____

HAVE YOU OR A FAMILY MEMBER HAD ANY PROBLEM WITH ANESTHESIA? ❒ NO ❒ YES

CURRENT MEDICATIONS (Including Vitamins, Appetite Suppressants & Herbal Supplements)

____

____

PHARMACY ____________________________________PHONE # _____________________

HAVE YOU USED A RETINOID OR ACCUTANE IN THE LAST 6 MOS.? ❑NO ❑YES

DO YOU TAKE ASPIRIN? ❑NO ❑YES (HOW OFTEN?) _____________________________

DO YOU HAVE ANY DRUG ALLERGIES? ❑NO ❑YES _____________________________

PLEASE LIST: ____

HEREDITARY DISORDERS (IN THE FAMILY, DIABETES, CANCER, HYPERTENSION, HEARTDISEASE)

____

____

DO YOU SMOKE? ❑NO ❑YES (HOW LONG AND HOW MUCH?) ____________________

DO YOU HAVE A SMOKING HISTORY OF 20 YEARS OR MORE? ❒ NO ❒ YES

DO YOU DRINK? ❑NO ❑YES (HOW LONG AND HOW MUCH?) ____________________

IS THERE ANY ADDITIONAL INFORMATION RELEVANT TO YOUR MEDICAL HISTORY THAT YOU FEEL IS IMPORTANT? ❑NO ❑YES

PLEASE EXPLAIN:

____

____