

DAVID E. MARTIN M.D.
PLASTIC SURGERY

Diplomat American Board of Plastic Surgery
Member of American Society of Plastic and Reconstructive Surgeons, Inc.
Member of Board Certified Plastic & Cosmetic Surgeons of Dallas

Today=s Date-_____/_____/_____

Patient=s Full Name _____ Male ___ Female ___ Birth Date ___/___/___
Driver=s License#- _____ SS#- _____ Marital Status _____ Age _____
Address _____

Street _____ City _____ State _____ Zip _____
Home Telephone Number(_____) _____ Business # (_____) _____ ext _____
Cell Number(_____) _____ Pager # (_____) _____
E-Mail address- _____ Patient=s Employer _____
Spouse=s Name _____ Employer _____ Business# (_____) _____ ext- _____

How did you hear about us? _____ Who may we thank for referring you? _____

Is this visit the result of : Accident? _____ Motor vehicle related? _____ Work related? _____
Date of accident ___/___/___

Nearest Relative or Friend not living with you _____
Name _____ Address _____ Phone _____

Responsible Party (if patient is a minor) or Insured Information IF DIFFERENT FROM PATIENT
Full name _____ Birth Date _____
Driver=s License # _____ SS# _____

Primary Insurance:

Company: _____ Address _____
Phone:(_____) _____ Policy # _____ Group # _____
Insured=s Name _____ Insured=s SS# _____ Relationship to Patient _____

Person to Notify in case of Emergency:

Name _____ Phone(_____) _____

Primary Care Physician

Name _____ Address _____ Phone#(_____) _____

Reason for consultation -in your own words -what is it that you would like to see changed and in what way ?

Height _____ Weight _____ Your normal weight is _____ Last time at this weight _____

Allergies or intolerance to medications _____

Medications taken daily: include name, dosage, and length of time: _____

Over the counter medications taken, including aspirin, diet pills, sleeping pills, vitamins, & herbs-

Drug Dependance Yes ___ No ___ Alcohol Dependance Yes ___ No ___

PLEASE CONTINUE ON NEXT PAGE!!

Previous surgery: _____

Anesthesia problems(nausea/vomiting , slow to wake up, high temperatures?)- _____

Past hospitalizations _____

Have you Ever Had:

Hepatitis/Jaundice	Yes _____ No _____	Any recurrences? _____		
Epilepsy or seizures	Yes _____ No _____		Thyroid problems	Yes _____ No _____
High Blood Pressure	Yes _____ No _____		Ulcers	Yes _____ No _____
Heart attack	Yes _____ No _____		Cold Sores	Yes _____ No _____
Mitral Valve Prolapse	Yes _____ No _____		Stroke	Yes _____ No _____
Prior Blood Transfusion	Yes _____ No _____		Diabetes	Yes _____ No _____
Emphysema, asthma,			Kidney problems	Yes _____ No _____
shortness of breath	Yes _____ No _____			

Have you had any testing for the following?:

Tuberculosis	Yes _____ No _____	Date _____	Results _____
HIV	Yes _____ No _____	Date _____	Results _____
Hepatitis	Yes _____ No _____	Date _____	Results _____

Condition of Teeth: Caps or dentures? Yes _____ No _____ Problem teeth: _____

Date of last physical _____ Physician _____ Finding _____

EKG _____ Last blood work- _____

Do you Drink alcohol _____ Yes _____ No _____ How much & how often? _____

Do you smoke _____ Yes _____ No _____ for how long? _____ yrs/months. How much _____ packs/day.

If you have stopped smoking- for how long have you stopped _____ mo/ years.

Do you use any other tobacco products or use a nicotine patch- _____

FEMALE PATIENTS ONLY:

Abnormal Bleeding Yes _____ No _____ When _____

Anemia Yes _____ No _____ Currently? _____

Children:(names & ages) _____

Did you breast feed? _____ For how long _____

How did your breasts change after breast feeding? _____

breast lumps Yes _____ No _____ Biopsies? _____ Results _____

Have you or any family member had any breast cancer? _____

If yes explain _____

Have you or any family member had any connective tissue diseases(rheumatoid arthritis, Lupus, Scleroderma, etc)?

Your last mammogram _____ Findings _____ Location _____

- 1.) The above information is current and correct to the best of my knowledge:
- 2.) You may use my photos to show to medical or non medical audiences and my use them in medical or non medical publication and I hereby authorize you to release my medical records to insurance companies.
- 3.) I give my permission to be treated by Dr. David Martin and his staff and assign all benefits directly to Dr. Martin. I understand that I am responsible for payment for any services rendered, whether or not covered by said benefits. I assume full responsibility for my balance regardless of the status of my insurance claim.
- 4.) If computer imaging is used in my evaluation I understand that the alteration is purely for the purpose of illustration and discussion and in no way constitutes an expressed or implied warranty as to my final results and appearance.

Signature _____