

# Resident Cosmetic Clinic

APPLICATION 1/2

**UTSouthwestern**  
Medical Center

Department of Plastic Surgery

## PERSONAL INFORMATION

Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, ZIP, State: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Age: \_\_\_\_\_ Gender: M F O \_\_\_\_\_ Single ☐ Married ☐ Other \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Email: \_\_\_\_\_ May we contact you via email? Yes No  
Phone Home: \_\_\_\_\_ Y N Cell: \_\_\_\_\_ Y N  
May we leave a message for you at this number? May we leave a message for you at this number?  
*We do not share email or telephone information with third parties.*

How did you hear about our Resident Clinic? \_\_\_\_\_  
Do you have a preferred resident? \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_  
Phone: Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

## Aesthetic Interests

### FACE: SURGICAL

- ☐ Facelift
- ☐ Necklift
- ☐ Browlift
- ☐ Blepharoplasty (eyelids)
- ☐ Liplift (upper lip)
- ☐ Rhinoplasty (nose)
- ☐ Otoplasty (ears)

### FACE: NON-SURGICAL

- ☐ BOTOX® (Botulinum Toxin Type A)
- ☐ Fillers (face, lips)
- ☐ Fat injection
- ☐ Laser facial resurfacing
- ☐ Laser hair removal
- ☐ Chemical peel

### BREAST

- ☐ Breast augmentation
- ☐ Breast reduction (cosmetic)
- ☐ Mastopexy (breast lift with or without augmentation)
- ☐ Gynecomastia (male breast reduction)

### BODY

- ☐ Abdominoplasty (tummy tuck)
- ☐ Brachioplasty (upper arm lift)
- ☐ Thighplasty (thigh lift)
- ☐ Liposuction
- ☐ Fat injection
- ☐ Laser hair removal (legs, bikini area, arms)

**OTHER, PLEASE SPECIFY:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Resident Cosmetic Clinic

## APPLICATION 2/2

This is part of your CONFIDENTIAL medical record

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for consultation: \_\_\_\_\_

Medications taken regularly, with dosages: \_\_\_\_\_

Any medications containing aspirin or ibuprofen? \_\_\_\_\_

Vitamins/herbs/fish oil? \_\_\_\_\_

Drug allergies: \_\_\_\_\_

Have you ever had any reaction to injections of a local anesthetic? \_\_\_\_\_

Are you allergic to Band-aids, tape, or adhesive? \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Primary care physician: \_\_\_\_\_

Previous surgeries, dates, and physicians: \_\_\_\_\_

## GENERAL HEALTH - Answer all

### YES NO

- |                          |                          |                         |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye problems            |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure     |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease           |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer type: _____      |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung problems           |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric disorders   |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurological disorders  |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever         |
| <input type="checkbox"/> | <input type="checkbox"/> | Get nauseated easily    |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruise easily           |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis               |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV or HIV risk factors |

DO YOU SMOKE: ☐ YES ☒ NO

How much alcohol do you drink?

How often? \_\_\_\_\_

Have you had an Electrocardiogram (EKG) in the past year? \_\_\_\_\_

Normal? \_\_\_\_\_

Have you been under a physician's care in the past or currently for any medical condition?

If so, what condition and who is/was the physician? \_\_\_\_\_

## FOR FEMALE PATIENTS ONLY

Are you taking oral contraceptives? \_\_\_\_\_ Are you pregnant or trying to become pregnant? \_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_

How many children do you have? \_\_\_\_\_ Did you breast feed? \_\_\_\_\_

Have you had a mammogram in the past year? \_\_\_\_\_ Normal? \_\_\_\_\_

Do you have a mother or sister with breast cancer? \_\_\_\_\_

Form completed by: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Date: \_\_\_\_\_

# Resident Cosmetic Clinic

## CONSENT FORM, 1/2

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### NEW PATIENT PAPERWORK

The Resident Cosmetic Clinic Coordinator and a Chief Resident review new patient paperwork every Monday. After review, the applicant will be contacted by the Clinic Coordinator to schedule a consultation. All consult appointments are on the 5th Floor of the Outpatient Building.

Please send completed paperwork to:

**Department of Plastic Surgery - Resident Cosmetic Clinic**

**1801 Inwood Rd. 4th Floor, Dallas, TX 75390-9132**

**or fax to: 214-645-3148**

### NEW PATIENT CONSULTATION FEE - \$125 (\$175 MASSIVE WEIGHT LOSS BODY CONTOURING)

This consult fee is collected at time of the first consultation. This fee covers the cost of fees of the resident clinic, all doctor visits, as well as any pre- and post-operative photos taken over the course of treatment. The consultation fee does NOT apply to the cost of surgery.

**Please be informed, if not mentioned prior to your consultation, you will be placed with any of our Chief/Senior Residents.**

In the new patient consultation, the patient will meet the Chief/Senior Resident to discuss procedures of interest, take preoperative photographs, and discuss related fees with the Resident Cosmetic Clinic Coordinator. Recommendations may be given on the steps necessary to obtain maximum results. Although there may be several procedures of interest, the new patient consultation will be focused on procedures medically feasible in one setting and most desired by the patient at the time. Once one successful surgery has taken place, and adequate healing time allowed, the patient can return (without repeating the entire process) for the remaining interests. Please note this may incur another consultation fee and/or photographs of the anatomical region of interest.

### A CONSULTATION DOES NOT GUARANTEE SURGERY.

We utilize UT Southwestern's Outpatient Building (Outpatient Surgery Center) for clinical visits (i.e., new patient consultations, pre- and post-operative visits, laser procedures, and follow-up visits). At any given time, the patient could be asked to follow-up at the facility, based on the Chief/Senior Resident's academic rotation schedule. This is to ensure the patient can be evaluated within the appropriate time necessary for care.

### SURGERY

The decision to proceed with surgery will be based on eligibility. The Chief/Senior Resident will schedule surgery after assessing the patient's health which includes a history and physical exam, the ability to achieve realistic positive results, availability of time on the operating room schedule, and the Chief/Senior Resident's educational requirements according to the planned procedures. This may not necessarily take place within a short period of time or within patient's desired timeframe; but rather when feasible for all three parties involved. Surgeries are scheduled around the Chief/Senior Resident's academic rotation schedule.

### WE REQUEST FLEXIBILITY IN THE SCHEDULING PROCESS.

We request flexibility and understanding. It is very important to make sure accurate contact information is given, as this part of the process will depend heavily on communication. We utilize various facilities. Several factors are involved in determining which facility will be used for your surgery. These factors include: availability, patient preference, fees, and accessibility.

### **PAYMENT**

Once the Chief/Senior Resident determines which surgical procedures are feasible, the patient will be given a price breakdown for all costs and procedures. This includes the surgeon, facility, and anesthesiology fees. Although the patient receives an estimate during the new patient consultation, a final quote is given once the surgery has been confirmed. If the patient agrees to the fees and wishes to proceed with surgery, a \$500 non-refundable deposit is due once an initial date for surgery has been scheduled. This deposit will be applied toward the total surgery cost.

### **PAYMENT IN FULL IS DUE AT LEAST 3 WEEKS PRIOR TO SURGERY**

It is the patient's responsibility to pay in a timely manner. Failure to pay in the 3-week timeframe may result in cancellation or delay of surgery, and loss of the \$500 non-refundable deposit. Every method of payment is accepted in the Resident Cosmetic Clinic... except cash, personal checks, insurance, Care Credit, and medical flex card.

### **FOLLOW-UP**

All post-operative patients are required to follow up 1 week after surgery. Post-operative follow-up visits are determined by the Chief/Senior Residents as needed for your care. These visits are scheduled depending on the Chief/Senior Resident's academic rotation.

### **CANCELLATION**

Because of the high demand and limited availability of operating room time, cancellations may delay your surgery for several months, and surgery may sometimes not be rescheduled. Once you have been scheduled and confirmed for surgery, please call the Resident Cosmetic Clinic Coordinator to settle fees and avoid canceling your surgery time.

### **IMPORTANT INFORMATION**

My signature indicates I have read and understand the processes involved with the Resident Cosmetic Clinic, and agree to the contents therein:

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_