Arizona Center for Aesthetic Plastic Surgery
Steven H. Turkeltaub, M.D., P.C.

Certified, American Board of Plastic Surgery

Date_____ Referred By:_____

Patient Last Name | First | M.I. | Sex | Marital Status | Date of Birth | Age

Present Mailing Address - Street | City | State | Zip | Social Security #

Home Telephone # | Cell phone # | Business Telephone # | E-mail address

Patient's Occupation | Patient's Employer | City | State

IN CASE OF EMERGENCY CONTACT:

Last Name | First | Middle | Relationship | Telephone #

Address | City | State | Zip

WHO WILL BE RESPONSIBLE FOR THE PATIENT'S MEDICAL EXPENSES?

Last Name | First | M.I. | Relationship | Social Security # | Telephone #

Responsible Party's Address – Street | City | State | Zip | Telephone #

Responsible Party's Employer and Address | Business Telephone #

INSURANCE INFORMATION: PLEASE COMPLETE IN FULL

Name of Insurance Company | Group Number | Medicare Number | Policy Number

Insurance Company Address | Name of Policy Holder | Date of Birth

Secondary Insurance Company | Group Number | Policy Number

Secondary Insurance Company Address | Name of Policy Holder

I hereby authorize the release of any information required in the course of my examination or treatment.
I hereby authorize payment of medical benefits directly to STEVEN H. TURKELTAUB, M.D., P.C.
I understand that I am financially responsible for charges not covered by this authorization.
I understand that payment is due at the time of service unless previous arrangements have been made.

_____ _____
Signature Date

IF PATIENT IS A MINOR, PLEASE SIGN

I, _____(Parent or Guardian) of the named minor give my consent for medical and/or surgical treatment by **Steven H. Turkeltaub, M.D. P.C.**

_____ _____
Signature Date