

# 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

**Arizona Center for Aesthetic Plastic Surgery**

**Steven H. Turkeltaub, M.D., P.C.**

*Certified, American Board of Plastic Surgery*

**Please complete all items and print**

Date \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

How were you referred here? Internet \_\_\_\_\_ Physician \_\_\_\_\_ Patient \_\_\_\_\_ Family \_\_\_\_\_ Friend \_\_\_\_\_ Insurance \_\_\_\_\_ Yellow Pages \_\_\_\_\_  
Other \_\_\_\_\_ None \_\_\_\_\_ Name of Referral or Website \_\_\_\_\_

**PLEASE DESCRIBE THE REASONS FOR YOUR CONSULTATION.** (Include all relevant information)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Ideal weight \_\_\_\_\_ Have you been trying to lose weight? Yes \_\_\_\_\_ No \_\_\_\_\_

Any weight loss? Yes \_\_\_\_\_ No \_\_\_\_\_ How much? \_\_\_\_\_ Over what period of time? \_\_\_\_\_

Have you ever smoked? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, do you still smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ How many packs per day? \_\_\_\_\_

At what age did you start? \_\_\_\_\_ At what age did you stop? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ What and how much? \_\_\_\_\_

If you follow an alternate, non-medically prescribed diet, check which one(s) apply: Vegetarian \_\_\_\_\_ Vegan \_\_\_\_\_ Other \_\_\_\_\_

Describe: \_\_\_\_\_

Do you use recreational drugs? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, drug and frequency \_\_\_\_\_

Have you ever had Hepatitis? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when? \_\_\_\_\_

Are you HIV+ or at high risk for acquiring AIDS? Yes \_\_\_\_\_ No \_\_\_\_\_

Will you have an HIV test if surgery is planned? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had anesthesia previously? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, any problems? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what? \_\_\_\_\_

**PREVIOUS COSMETIC PROCEDURES** (Please list)

Operation	Year	Surgeon's Name
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**(continued - please complete the next page of this form)**

**OTHER PREVIOUS SURGICAL PROCEDURES** (Please list)

Operation

Year

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**MEDICAL ILLNESSES**

Type

Treatment, if any:

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**MEDICATIONS** (List all medications and dosages including pain relievers, aspirin, birth control pills and steroids.)

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Do you have allergies to any medications? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list below:

Name of medication

Type of Reaction

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**SYSTEM REVIEW**

Have you had problems with any of the following? (If yes, check which ones.)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abnormal scars or keloids | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Liver Problems                 |
| <input type="checkbox"/> Burning eyes              | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Yellow Skin                    |
| <input type="checkbox"/> Blurred/Double Vision     | <input type="checkbox"/> Palpitations           | <input type="checkbox"/> Burning when urinating         |
| <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Numbness and tingling in hands |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Arthritis                      |
| <input type="checkbox"/> Nose Bleeds               | <input type="checkbox"/> Bleeding Problems      | <input type="checkbox"/> Seizures                       |
| <input type="checkbox"/> Sinus Problems            | <input type="checkbox"/> Stomach Pain           | <input type="checkbox"/> Emotional/psychiatric problems |
| <input type="checkbox"/> Shortness of Breath       | <input type="checkbox"/> Stomach/Duodenal Ulcer |   |

**MATERNAL HISTORY** (Women)

Have you ever been pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ How many times? \_\_\_\_\_ Number of children \_\_\_\_\_

Are you pregnant now? Yes \_\_\_\_\_ No \_\_\_\_\_ Are you planning more children? Yes \_\_\_\_\_ No \_\_\_\_\_

**FAMILY HISTORY**

Diabetes \_\_\_\_\_ Skin Cancer \_\_\_\_\_ Breast Cancer \_\_\_\_\_ Problems with anesthesia \_\_\_\_\_ Bleeding problems \_\_\_\_\_

**Arizona Center for Aesthetic Plastic Surgery**  
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**Consent for the Usage of Photographs**

I hereby give permission to **Steven H. Turkeltaub, M.D., P.C. (Arizona Center for Aesthetic Plastic Surgery)** to use my photographs for patient or public education or for any other purpose which **Dr. Turkeltaub** deems proper. This includes usage of them on our websites or other websites. My name will not be used in any case.

Unless the procedures or issues specifically involve the face and/or neck, I understand that my face will not be shown in the photographs.

I understand that all photographs taken of me are part of my medical record and the “property” of **Arizona Center for Aesthetic Plastic Surgery**. I relinquish any right, title or interest in these photographs.

Exceptions: \_\_\_\_\_

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

Printed name: \_\_\_\_\_

Witness: \_\_\_\_\_

Printed name: \_\_\_\_\_

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Would you like to receive an occasional e-mail from our office that may be of interest to you? These may contain such exciting and helpful information as what is new in Plastic Surgery as well as new services that we can offer you. If you are interested, please complete the following:

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

Primary e-mail address: \_\_\_\_\_

Secondary e-mail address: \_\_\_\_\_