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

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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

____

____

____

____

____

MEDICAL ILLNESSES

Type Treatment, if any:

____

____

____

____

____

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

____

____

____

____

____

____

Do you have allergies to any medications? Yes______ No______ If yes, please list below:

Name of medication Type of Reaction

____

____

____

____

____

SYSTEM REVIEW

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

_____ Abnormal scars or keloids
_____ Burning eyes
_____ Blurred/Double Vision
_____ Glaucoma
_____ Asthma
_____ Nose Bleeds
_____ Sinus Problems
_____ Shortness of Breath

______Diabetes
______Chest Pain
______Palpitations
______High Blood Pressure
______Headaches
______Bleeding Problems
______Stomach Pain
______Stomach/Duodenal Ulcer

______Liver Problems
______Yellow Skin
______Burning when urinating
______Numbness and tingling in hands
______Arthritis
______Seizures
______Emotional/psychiatric problems

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_____

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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: ____

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Permission for Verbal Communications

Patient Name___________________________________ Date of Birth____________________

I give permission to **Dr. Steven Turkeltaub** and his staff ("Health Care Providers") at the **Arizona Center for Aesthetic Plastic Surgery** to discuss health information - in person or by telephone - with the family members, friends and specified persons listed below who are involved in my medical care.

This authorization is limited to discussions regarding and relating to the following medical condition(s)/issue(s):

____

____

	Name	Relationship
1.	____	________________________________
2.	____	________________________________
3.	____	________________________________
4.	____	________________________________

I also give permission to release any written health information to the following individuals (or write "none" if no permission is granted): ____.

This authorization is limited to the following time frame from _________________ (date) to ___________________ (date). If no dates are indicated, this form will remain in effect for an unlimited an amount of time.

If at any time I do not want verbal discussions to be permitted between my "Health Care Providers" and any of the individuals named above and/or I rescind permission to release any of my written medical records to an individual listed above, I must notify my "Health Care Providers" in writing.

Patient/Legal Guardian Signature _________________________________ Date _____________

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Permission for Email and Message Communications

Patient Name__________________________________ Date of Birth____________________

I give permission to **Dr. Steven Turkeltaub** and his staff ("Health Care Providers") at the **Arizona Center for Aesthetic Plastic Surgery** to discuss or provide my health information through the following technological means:

1. Can leave a voicemail message at this/these numbers: ____________________________
2. Can respond to all my emails and email me at: __________________________________

This authorization is limited to the following time frame from ___________________ (date) to _____________________ (date). If no dates are indicated, this form will remain in effect for an unlimited an amount of time.

If at any time I do not want to receive my health information this way, I must notify my "Health Care Providers" in writing.

Patient/Legal Guardian Signature ________________________________ Date _____________

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Pharmacy Information

Patient Name______________________________________

Primary Pharmacy:

Pharmacy Name_____________________________ Telephone #______________

Street Address____

City_____________________________ State__________ Zip code_____________

Alternate Pharmacy:

Pharmacy Name_____________________________ Telephone #______________

Street Address____

City_____________________________ State__________ Zip code_____________