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_____

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COVID-19 INFORMED CONSENT AGREEMENT

☐ I, the undersigned patient, consent to have Dr. Turkeltaub and/or his staff (hereinafter collectively "Dr. Turkeltaub") perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand having my procedure performed at this time, despite my own efforts and those of Dr. Turkeltaub, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in Dr. Turkeltaub's office or in a hospital/outpatient center, may result in a more severe case of COVID-19 than I might have had without the procedure.

☐ I also understand having my procedure performed at this time increases the risk of my transmission of COVID-19 to Dr. Turkeltaub. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at Dr. Turkeltaub's office, I accept that he will implement infection-control procedures with which I must comply, before, during and after my procedure, for my own protection as well as that of Dr. Turkeltaub. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures to be necessary.

☐ I have informed Dr. Turkeltaub of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to him. I understand that he may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to him before I may have my procedure.

☐ I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf, which website I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting myself and others at risk.

☐ All topics above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my procedure until the COVID-19 pandemic is less prevalent, but I choose to have my procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

_____ _____

Patient/Authorized Representative Signature | Print Name & Date

_____ _____

Witness Signature | Print Name & Date