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. Date of Birth Age

Preferred Last Name Preferred First Name Preferred Middle Name Marital Status

Gender at Birth: Male/Female/Other **Gender Identity:** Male/Female/Non-binary/Other **Preferred Pronoun:** He/She/They/Other

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

Arizona Center for Aesthetic Plastic Surgery
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Please complete all items and print

Date_____

Name_____ Age_____ Date of birth_____

Gender at Birth: Male/Female/Other Gender Identity: Male/Female/Non-binary/Other Preferred Pronoun: He/She/They/Other

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 use nicotine in any form? Yes____ No_____

Do you vape? Yes____ No____ If yes, how often? _____

Do you smoke marijuana? Yes____ No____ If yes, how often? _____

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, commercial or non-commercial, which the corporation may deem proper. This includes usage of them on the Internet such as on a web site.

My name will not be used in any case. Furthermore, in photos of any part of my body aside from those involving my face, I understand that my face will not be shown.

I understand that these and any additional photographs taken are the property of **Steven H. Turkeltaub, M.D., P.C. /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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Important – Please Read Carefully

It is the responsibility of our insured patients to be aware of any restrictions or requirements stated in their insurance policy. These include second opinions, policy exclusions or waived benefits, pre-certification, inpatient vs. outpatient benefits and restrictions regarding pre-existing conditions.

Our office policy is to contact your insurance carrier for pre-surgical authorization. However, a pre-authorization or pre-certification issued by your insurance company simply means that they agree that your surgery is medically necessary though they can reverse this. It **does not guarantee** 1) payment of our charges if your insurance is an indemnity plan or 2) payment of your insurance company's allowable charges if your insurance is a managed care plan. Your insurance benefits and the payment we receive are determined by the limits that your insurance carrier sets. Again: **pre-certification does not guarantee payment.**

If you have any reason to believe that your insurance company will not cover your surgery because of a pre-existing clause, deductible, etc. please discuss this with us or your insurance company **prior** to your surgery.

I have read and understand your office policy.

_____ _____

Patient Signature (or responsible party) Date

_____ _____

Witness Date

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I authorize and request that payments under my insurance program be made directly to the above provider for any services furnished to me (myself, dependent, spouse, etc.). I also authorize the provider to release any information needed for payment of claims. I further permit copies of this authorization to be used in place of the original.

I agree to pay the following, as determined and selected by the billing department:

1) Any unpaid balance not covered by my insurance carrier.
2) On any balance over 120 days from time of service a 12% interest rate per annum on the total balance for amounts greater than $500.00
3) On any balance over 120 days from time of service an $8.00 rebilling fee per month for balances less than $500.00.

I also agree to pay all costs of collection if needed to obtain payment.

In the event legal action should become necessary to collect an unpaid balance, I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

In the event the medical services provided are related to an accident/injury, I hereby authorize Steven H. Turkeltaub, M.D., P.C. to bill my primary insurance carrier first and collect any unpaid balance from the proceeds of any legal action resulting in a monetary settlement, regardless of any contracted provider agreement with my private insurance carrier.

This form will serve as a lien against any possible settlement through my attorney and I authorize that Steven H. Turkeltaub, M.D., P.C. be paid from the proceeds of current or pending legal action for his services.

_____

Patient (or responsible party)

_____

Date

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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_____