

# 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.

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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 \_\_\_\_\_ None \_\_\_\_\_

Other \_\_\_\_\_ Name of Referral or Website \_\_\_\_\_

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

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### 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 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
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(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

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

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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: \_\_\_\_\_

**Arizona Center for Aesthetic Plastic Surgery**  
**Steven H. Turkeltaub, M.D., P.C.**  
*Certified, American Board of Plastic Surgery*

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: \_\_\_\_\_

# Arizona Center for Aesthetic Plastic Surgery

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

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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):

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

	<b>Name</b>	<b>Relationship</b>
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 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 \_\_\_\_\_

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

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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 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 \_\_\_\_\_



# Arizona Center for Aesthetic Plastic Surgery

## Steven H. Turkeltaub, M.D.

### 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.

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Patient/Authorized Representative Signature

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Print Name & Date

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Witness Signature

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Print Name & Date