

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 _____ None _____

Other _____ 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.)

- | | | |
|--|---|---|
| <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 _____

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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 that I owe which is more than 90 days old, a 3% interest rate per annum will be added to the total balance.
- 3) There will be a rebilling fee of \$25 per month for any balance that I owe which is more than 90 days old.

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.

Signed: _____ Date: _____
Patient (or responsible party)

Printed Name: _____

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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 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 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 _____