

# 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

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

*Certified, American Board of Plastic Surgery*

### 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)

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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 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

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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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**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

**Arizona Center for Aesthetic Plastic Surgery**  
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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: \_\_\_\_\_

# 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 \_\_\_\_\_