

Toby R. Meltzer, MD, PC

Plastic and Reconstructive Surgery

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Scottsdale, AZ 85253

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PATIENT INFORMATION

LEGAL NAME: _____
(As shown on driver's license or other form of legal identification)

PREFERRED NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

SSN# _____

DATE OF BIRTH: _____ AGE: _____

SEX: M F MARITAL STATUS: S M D SEP

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____

EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT PERSON
OR PARENT'S NAME: _____ RELATION: _____
PHONE #: _____

DRUG ALLERGIES:

FOOD AND/OR OTHER ALLERGIES:

It may be necessary for Dr. Meltzer to take photographs to document your current condition. Your signature below authorizes Dr. Meltzer to use your photographs for educational purposes. Please know that these educational tools will in no way disclose your identity by name.

Signature _____ Date _____

Printed Patient Name: _____

Procedure(s) you are interested in having:

Would you be willing to speak with potential patients after your surgery is performed?

Yes _____ No _____

Do you want to have visitors? Yes _____ No _____

	<u>Name</u>	<u>City</u>	<u>Phone</u>
Primary Therapist	_____	_____	_____
Secondary Therapist	_____	_____	_____
Electrologist	_____	_____	_____
Referring Physician:	_____	_____	_____
Endocrinologist	_____	_____	_____
Primary Care Physician	_____	_____	_____

We keep a referral database of the above providers, would you like to add your provider to our list?
If yes, which one(s)? _____

RLT Start Date: _____

Important Insurance Information:

Dr. Meltzer presently does not participate with any insurance providers.

The hospital will not provide you with an itemized bill to submit to your insurance carrier. Their fees are negotiated on a cash pay basis only.

Medicare does require us to obtain a waiver of non-coverage. It is your responsibility to inform us if you are covered by Medicare so that we may provide you with this form.

Are you covered under Medicare? Yes _____ No _____

Signature

Date