

**Toby R. Meltzer, MD, PC**

Plastic and Reconstructive Surgery

7025 N. Scottsdale Rd. Ste 302  
Scottsdale, AZ 85253

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**PATIENT INFORMATION**

NAME: \_\_\_\_\_

AKA: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

SSN# \_\_\_\_\_

SEX: M F MARITAL STATUS: S M D SEP

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP \_\_\_\_\_

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 \_\_\_\_\_

Name

City

Phone

Referring Physician: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

**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