

Toby R. Meltzer, MD, PC

Plastic and Reconstructive Surgery

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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 ___ Other ___ 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:	_____	_____	_____
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: _____

Signature

Date