T.A. CULBERTSON, M.D.

(301) 694-8999

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ______________________________
First Middle Last

Address ______________________________
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Other Phone ____________

Any restrictions for contacting you? ❐ No ❐ Yes E-mail ____________

Contact Restrictions: ____________

Age ______ Birthdate ____________ Gender Male or Female

Marital Status ❐ Single ❐ Married to: ____________ ❐ Other: ____________

Patient's Employer ____________ Occupation ____________

Work Phone ____________ Ext: ______ Is it okay to call you at work? ❐ Yes ❐ No

Address ______________________________
Street & Suite # City State Zip

How did you hear about Dr. Culbertson? (Mark all that apply)

❐ TV News ❐ TV Ad ❐ Phone Book ❐ Magazine ❐ Newsletter ❐ Seminar ❐ Salon ❐ Web

❐ Friend/Relative: ____________ ❐ Doctor: ____________ ❐ Other: ____________

If you were referred by a specific person, may we thank them? ❐ Yes ❐ No

Primary Car Doctor Name: ____________ **Preferred Pharmacy:** ____________

Emergency Contact ____________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Other Phone ____________

Areas of Interest: (mark all that apply)

Facial Procedures

- ❐ Blepharoplasty (Eyelid Lift)
- ❐ Brow or Forehead Lift
- ❐ Earlobe Repair
- ❐ Facial Liposuction (Neck, Jowls)
- ❐ Face or Neck Lift
- ❐ Otoplasty (Ear Pinning)
- ❐ Rhinoplasty (Nose Reshaping)

Breast Procedures

- ❐ Breast Augmentation
- ❐ Breast Reconstruction
- ❐ Mastopexy (Breast Lift)
- ❐ Nipple Reduction or Inversion

Body Procedures

- ❐ Abdominoplasty (Tummy Tuck)
- ❐ Liposuction (Thighs, Abdomen, Etc.)
- ❐ Thigh or Buttock Lift
- ❐ Lesions / Moles

I understand that office visit charges are payable on the day service is rendered.

Signature ______________________________ **Date** ____________

Please continue to the next page →

Patient:			
DOB:	Age:	Marital Status:	Weight lbs
Occupation:	Gender: ☐ Male ☐ Female		Height ft in

Purpose of Visit: ______________________________

____

Medical History (anything for which you take medicine, see your doctor, etc.)

____

____

____

Previous Surgeries with Dates: (including cosmetic, dental, minor procedures)

____

____

____

Do you smoke? No Yes If yes, how much? ________ Pack(s)/day How long? ________ Years

Do you drink alcohol? No Yes If yes, how much? ________________ How often? ________________

Do you use recreational drugs? No Yes If yes, describe: ______________________________

Do you have bleeding or bruising problems? No Yes If yes, describe: ______________________________

Do you have problems with scarring? No Yes If yes, describe: ______________________________

Do you have any history of problems with anesthesia? No Yes If yes, describe: ______________________________

Drug or Latex Allergies: (*please indicate if none*)

____

____

Medications: (include all Prescription, over-the-counter, vitamins and herbal medications taken *regularly*)

____

____

____

____

____

Primary Physician ______________________________ Phone ______________________________

First and Last Name

Date of Last Physical: ________________

Please continue on the next page →

T.A. CULBERTSON, M.D. **(301) 694-8999**

77 Thomas Johnson Drive, Suite J , Frederick, MD 21702

Patient:

DO YOU NOW OR HAVE YOU EVER HAD……….. **(Please circle an answer for each individual item)**

Question			Question		
Rheumatic fever?	Yes	No	DVT (leg clots)? Pulmonary embolus (clot to lung)?	Yes	No
Heart murmur? Mitral valve prolapse? Damaged heart valve?	Yes	No	Convulsions? Epilepsy?	Yes	No
Do you have to take antibiotics before having dental work done?	Yes	No	Stroke?	Yes	No
High blood pressure?	Yes	No	Wear glasses or contact lenses?	Yes	No
Low blood pressure?	Yes	No	Diabetes (sugar)?	Yes	No
Chest pain (angina)? Heart attack(s)?	Yes	No	Kidney trouble? On dialysis?	Yes	No
Irregular heart beat? Pacemaker?	Yes	No	Acid indigestion? Stomach ulcers?	Yes	No
Congestive heart failure? Pulmonary edema (fluid in/on lungs) ?	Yes	No	Bowel trouble? Stools bloody or tarry? Constipation? Irritable bowel?	Yes	No
Shortness of breath? If yes: at rest? during exercise?	Yes	No	Problems of the immune system (lupus, rheumatoid arthritis, etc.)?	Yes	No
Pain in calves with walking? Foot pain during sleeping hours?	Yes	No	Goiter or thyroid disorders?	Yes	No
Asthma? Use an inhaler?	Yes	No	Skin disorders?	Yes	No
Emphysema? Other lung problems?	Yes	No	Mental health problems (depression, self-destructive behavior, anxiety, etc.) ?	Yes	No
Tuberculosis If yes: ACTIVE or INACTIVE	Yes	No	Chemotherapy? Radiation treatment?	Yes	No
Blood transfusion?	Yes	No	Eye trouble? Glaucoma? Dry eyes?	Yes	No
Blood disorder such as anemia?	Yes	No	Any family members with anesthesia problems (malignant hyperthermia) ?	Yes	No
Bleeding disorder (on blood thinners, too much bleeding from cut or tooth removal)?	Yes	No	Fractures or surgeries on neck or spine?	Yes	No
Yellow jaundice? Abnormal liver blood tests?	Yes	No	Dentures, bridges, capped teeth or crowns	Yes	No
Positive blood test for: HIV (AIDS), Hepatitis B or C	Yes	No	Other:		

If you answered "Yes" to any of the above questions, please use the space below to give any necessary details:

____

____

____

____

The above information is accurate and complete to the best of my knowledge.

Signature ______________________________ **Date** ________________

Please continue on the next page →

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by T.A. Culbertson, M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of T.A. Culbertson, M.D.. I understand that diagnosis or treatment of me by Dr. Tracey Culbertson may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. T.A. Culbertson, M.D. is not required to agree to the restrictions that I may request. However, if T.A. Culbertson, M.D. agrees to a restriction that I request, the restriction is binding on T.A. Culbertson, M.D. and Dr. Tracey Culbertson.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Tracey Culbertson or T.A. Culbertson, M.D. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review T.A. Culbertson, M.D.'s Notice of Privacy Practices prior to signing this document. The T.A. Culbertson, M.D.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the T.A. Culbertson, M.D.. The Notice of Privacy Practices for T.A. Culbertson, M.D. is also provided at our office. This Notice of Privacy Practices also describes my rights and the T.A. Culbertson, M.D.'s duties with respect to my protected health information.

T.A. Culbertson, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

By signing this form, you acknowledge that a copy of our notice has been provided to you, that you understand the contents of our notice and how it applies to you and that all of your questions regarding the contents of our notice have been answered.

____ ______________________________

Signature of Patient/Personal Representative/Legal Guardian Date

____

Print Name of Patient/Personal Representative/Legal Guardian