

**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 \_\_\_\_\_ SS# \_\_\_\_\_ Gender  Female  Male

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 \_\_\_\_\_

**Primary Care Doctor Name:** \_\_\_\_\_

**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

**Emergency Contact**

Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

**Primary Health Insurance Company**

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \_\_\_\_\_ Employer \_\_\_\_\_

**Policy Holder:**

Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

**Secondary Health Insurance Company**

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \_\_\_\_\_ Employer \_\_\_\_\_

**Policy Holder:**

Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Culbertson to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Culbertson and myself.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# T.A. CULBERTSON, M.D.

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

|                 |  |                |              |
|-----------------|--|----------------|--------------|
| <b>Patient:</b> |  |                |              |
| DOB             | Age  | Marital Status | Weight lbs   |
| Occupation:     | Gender <input type="checkbox"/> Male <input type="checkbox"/> 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)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 →**

**Patient:** \_\_\_\_\_

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

|  |     |    |
|--|-----|----|
| Rheumatic fever?   | Yes | No |
| Heart murmur? Mitral valve prolapse?<br>Damaged heart valve?                           | Yes | No |
| Do you have to take antibiotics before having<br>dental work done?                     | Yes | No |
| High blood pressure?   | Yes | No |
| Low blood pressure?  | Yes | No |
| Chest pain (angina)? Heart attack(s)?  | Yes | No |
| Irregular heart beat? Pacemaker?   | Yes | No |
| Congestive heart failure? Pulmonary edema<br>(fluid in/on lungs) ?                     | Yes | No |
| Shortness of breath?<br>If yes: at rest? during exercise?                              | Yes | No |
| Pain in calves with walking? Foot pain during<br>sleeping hours?                       | Yes | No |
| Asthma? Use an inhaler?  | Yes | No |
| Emphysema? Other lung problems?  | Yes | No |
| Tuberculosis<br>If yes: ACTIVE or INACTIVE   | Yes | No |
| Blood transfusion?   | Yes | No |
| Blood disorder such as anemia?   | Yes | No |
| Bleeding disorder (on blood thinners, too much<br>bleeding from cut or tooth removal)? | Yes | No |
| Yellow jaundice? Abnormal liver blood tests?   | Yes | No |
| Positive blood test for:<br>HIV (AIDS), Hepatitis B or C                               | Yes | No |

|   |     |    |
|---|-----|----|
| DVT (leg clots)? Pulmonary embolus (clot to<br>lung)?                               | Yes | No |
| Convulsions? Epilepsy?  | Yes | No |
| Stroke?   | Yes | No |
| Wear glasses or contact lenses?   | Yes | No |
| Diabetes (sugar)?   | Yes | No |
| Kidney trouble? On dialysis?  | Yes | No |
| Acid indigestion? Stomach ulcers?   | Yes | No |
| Bowel trouble? Stools bloody or tarry?<br>Constipation? Irritable bowel?            | Yes | No |
| Problems of the immune system (lupus,<br>rheumatoid arthritis, etc.)?               | Yes | No |
| Goiter or thyroid disorders?  | Yes | No |
| Skin disorders?   | Yes | No |
| Mental health problems (depression, self-<br>destructive behavior, anxiety, etc.) ? | Yes | No |
| Chemotherapy? Radiation treatment?  | Yes | No |
| Eye trouble? Glaucoma? Dry eyes?  | Yes | No |
| Any family members with anesthesia<br>problems (malignant hyperthermia) ?           | Yes | No |
| Fractures or surgeries on neck or spine?  | Yes | No |
| Dentures, bridges, capped teeth or crowns   | 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 →**

Insurance Information & Authorization

(Please Print Legibly & Sign)

Patient's Name

First

Middle

Last

**Basic Policy** - Payment for service is due in full at the time of service is provided in our office.

**Surgical Center Policy** – You will be billed for the Physician fee from Dr. Culbertson and a separate bill for the use of the surgical center (Physicians Surgery Center of Frederick, Frederick Surgical Center, Frederick Memorial Hospital). You may be responsible for two separate co-pays per your insurance for the physician and facility.

**Surgery Fees** – All co-pays, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. Your carrier may require prior authorization. All anesthesia and laboratory fees will be billed directly to the patient.

**For Patients with Insurance** – We bill most insurance carriers for you if the proper paperwork is provided to us. Referrals (if required) must be obtained and brought to our office for initial consultations and follow-up visits. Co-payments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. **If an insurance carrier has not paid within 90 days of billing, facility/surgery fees are due and payable in full from you.**

**Medicare Patients** – We will bill Medicare for you. We will also bill secondary insurances for you. All co-payments or deductibles are due and payable at the time service is provided.

**Non-covered Services** – Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of the insurance claim denial.

**Missed Appointments** – In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.

**All Insurance Patients – Signature on File**

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.

Beneficiary

Date

Signature

Please continue on the next page →

## Consent for Purposes of Treatment, Payment and Healthcare Operations

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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.

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Signature of Patient/Personal Representative/Legal Guardian

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Date

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Print Name of Patient/Personal Representative/Legal Guardian