Plastic and Reconstructive Surgery of Sumter, P.A.

Gary R. Culbertson, M.D.
18 Miller Road
Sumter, SC 29150
(803) 773-6361

Patient Information

Today's Date _____ Referred to our office by _____

Reason for today's visit _____

Name _____ (Last / First / MI) Birthdate _____ Age _____

Home Address _____ Home Phone ( ) _____

City _____ State _____ Zip _____

Marital Status: M ____ S ____ Sep ____ Wid ____ Div ____ Sex: Male ____ Female ____

Social Security # _____ E-Mail _____

Employer _____ Work Phone ( ) _____

Address _____

Insurance Carrier _____ ID/Policy # _____

Spouse/Responsible Party Information

Name _____ (Last / First / MI) Birthdate _____ Age _____

Phone ( ) _____ Relationship to patient _____

Social Security # _____ E-Mail _____

Employer _____ Work Phone ( ) _____

Address _____

Insurance Carrier _____ ID/Policy # _____

Medical Information

Family Physician _____ Height _____ Weight _____

Have you ever or are you currently being treated for any of the following? _____

Heart Problems _____ Blood Pressure _____ Lung Problems _____ Bleeding Disorders _____

Any known allergies to medications, please list _____

List all medications currently being taken _____

_____

Are you taking aspirin? _____ Are you pregnant? _____ Have you ever taken cortisone? _____

Are you presently under another doctor's care? _____

What pharmacy do you use? _____

(Please complete information on back of form)

Accident/Injury Information

Date of injury_____ Result of: Auto accident_____ Work related_____

What injury did you sustain and please describe?_____

_____

Emergency Information

Please provide us with the name, address and telephone number of a friend or relative that we may contact in case of an emergency.

Name_____ Phone ( )_____

Address_____

Acknowledgment of Responsibility

I have completed this form fully and completely, and certify that I am the duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though there is some type of insurance coverage, I am responsible for payment of services. I authorize the release of medical records information to my insurance company and request that payments be made directly to Gary R. Culbertson, M.D. Plastic & Reconstructive Surgery of Sumter, P.A.

_____
Signature of authorized person

Consent to take Photographs

Plastic & Reconstructive Surgery of Sumter, P.A. requests that photographs be taken of patients before, during and after any procedure for medical documentation. These photographs are used, if necessary, to submit to your insurance company for approval of surgical procedures. When these photographs are taken we will keep them confidential as reasonably as possible. We ask that you please read and sign this consent to allow your photographs to be taken and also to be viewed if necessary.

I authorize Plastic & Reconstructive Surgery of Sumter, P.A. to take photographs of me before, during, and after, office procedure, surgery, or clinic visit.

I permit these photographs to be submitted to my insurance company if necessary for authorization for surgery.

I permit these photographs to be viewed by others who wish to see before, during and after photographs.

_____
Signature

Authorization to release information

Patient name:_____ **Date:**_____

1. I authorize release of my medical records to the physician _____who referred me to Plastic & Reconstructive Surgery of Sumter, PA. / Gary R. Culbertson, M.D.

   ( ) Yes ( ) No

2. I authorize release of my medical records to my family physician if Dr. Gary R. Culbertson feels it will benefit my health care.

   ( ) Yes ( ) No

3. I give my permission to Dr. Gary R. Culbertson to discuss my health care with other health care professionals who may be participating in my current and future treatment. This includes release of my medical records.

   ( ) Yes ( ) No

4. I authorize you to discuss my health care with the people listed below:

_____	_____
Name	Relationship to patient
_____	_____
Name	Relationship to patient
_____	_____
Name	Relationship to patient

Patient or Guarantor Signature:_____

Todays date:_____

Plastic & Reconstrutive Surgery of Sumter
18 Miller Road
Sumter, SC 29150
(803) 773-6361
Gary R. Culbertson, M.D.

TO OUR PATIENTS

Missed appointments without notice is costly to the practice and to the patient. In order to keep our costs down, as well as our fees to you, we must implement a new cancellation policy effective 10/1/04. Please be informed that we require at least 24 hours notice to cancel or reschedule an appointment. After two missed appointments, you will be charged a fee of **$25.00**. If there is a third missed appointment, there will be a **$35.00** charge. Finally, if there are four no show appointments, your account will be evaluated, and notice may be given to you as the patient that you will be dismissed from the practice.

I have read and agree to comply with the above policy.

_____ _____

Signature of Patient/Guardian Date

9/30/04 cxl.pol sb