Culp Dental Patient Registration

(Please Print)

Today's Date: _____

Patient: |_____|_____|_____|_____

Last name First Name Middle Initial Preferred Name

Sex: _____ Circle one: Married / Single / Child / Other Birthdate:_____/_____/_____ SS# or DL#:_____

Address: |_____|_____|_____|_____

Street City State ZIP Code

Email:_____ Cell Phone: _____ Home Phone: _____

Employer/School_____ Occupation_____

Employer/School Address_____ Employer/School Phone_____

Spouse/Parent Name_____ Spouse/Parent Birthdate_____

Spouse/Parent Employer_____ Occupation_____

Business Address_____ Business Phone_____

Who is responsible for this account?_____ Relationship to Patient_____

Spouse/Parent's Social Security # or DL #_____

Dental Insurance Company_____ Group #_____ ID #_____

In case of emergency, who should be notified?_____ Phone_____

Whom may we thank for referring you?_____

Medical History

Please indicate with an (X) if you currently have or have ever had any of the following diseases, problems, or conditions:

__ Abnormal Bleeding/Hemophilia
__ AIDs or HIV infection
__ Anemia (Type: _____)
__ Angina
__ Arteriosclerosis
__ Arthritis
__ Artificial (Prosthetic) Heart Valves*
__ Asthma
__ Autoimmune Disease
__ Blood Thinners
__ Blood Transfusion (Date: _____)
__ Cancer/Chemotherapy/Radiation
__ Cardiovascular Disease
__ Chemical Dependency
__ Chest Pain Upon Exertion
__ Chronic Pain
__ Circulatory Problems
__ Congenital Heart Defects/Disease*
__ Congestive Heart Failure
__ Damaged Heart Valves
__ Diabetes (Circle: Type I or Type II)
__ Eating Disorder
__ Epilepsy
__ Fainting spells or seizures
__ Gastrointestinal Disease
__ G.E. Reflux/Persistent Heartburn
__ Glaucoma
__ Heart Attack
__ Heart Murmur
__ Hepatitis, Jaundice, or Liver Disease
__ High Blood Pressure
__ History of Bisphosphonate Medication
__ Kidney Problems
__ Low Blood Pressure
__ Mental Health Problems/Psychiatric Care
__ Mitral Valve Prolapse
__ Nervous Problems
__ Neurological Disorders
__ Osteoporosis
__ Pacemaker
__ Persistent Swollen Glands in Neck
__ Previous Infective Endocarditis*
__ Recurrent Infections
__ Respiratory Disease/Bronchitis/Emphysema
__ Rheumatic Fever
__ Rheumatic Heart Disease
__ Rheumatoid Arthritis
__ Severe Headaches/Migraines
__ Severe/Rapid Weight Loss
__ Sexually Transmitted Infection
__ Sinus Trouble
__ Sleep Disorder
__ Stroke
__ Systemic Lupus Erythematosus
__ Ulcers
__ Thyroid Problems
__ Total Joint Replacement*
__ Tuberculosis

Who is your primary care physician?_____ Date of Last Physical: _____/_____/_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ____ Yes ____ No

If yes, what specifically?_____

Have you every responded adversely to medical or dental treatment? ____ Yes ____ No

Are you taking any medication at this time? ____ Yes ____ No ; If yes, what specifically? _____

Have you been under the care of a physician for a specific medical condition/illness in the last 5 years? ____ Yes ____ No

If yes, what specifically? _____

Women Only: Do you suspect that you are pregnant? ____ Yes ____ No ; If yes, what is the due date? _____/_____/_____

Women Only: Are you nursing? ____ Yes ____ No

Is there anything else that we should know about your medical history? _____

Certification

To the best of my knowledge, the information I have provided on this form is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any error or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever had a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative | Date

_____ _____

Please Print name of Patient, Parent, Guardian, or Personal Representative | Relationship to Patient

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Compound Authorization for Release of Information

Culp Dental, PA is authorized to release protected health information about the above-named patient to the entities named below:
Entity to Receive Information. Check each that is subject to this authorization:

Voicemail/Answering Machine
___ Appointment times
___ Absentee information
___ Billing information

Information to employer/school
___ Appointment times
___ Absentee information

Spouse/Parent
___ Appointment times
___ Absentee information
___ Billing information

Text Message and Email
___ Appointment times

Other persons authorized to receive information:

Name:_____ Clinical:___ Financial:___

Name:_____ Clinical:___ Financial:___

Rights of the Patient:

-I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Culp Dental, PA. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

-I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

-I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization. This authorization shall be in effect until revoked by the patient or representative signing the authorization:

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative | Date

_____ _____

Please Print name of Patient, Parent, Guardian, or Personal Representative | Relationship to Patient