

Justin T. Chapman, D.D.S.

# PATIENT HISTORY

2800 Park Avenue, Suite B • Merced, CA 95348-3375  
(209) 383-3403

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
Residence - Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employed By \_\_\_\_\_  
Present Position \_\_\_\_\_  
Student - Full Time: Yes \_\_\_\_\_ No \_\_\_\_\_

Patient's Title: Mr. \_\_\_\_\_ Mrs. \_\_\_\_\_ Miss \_\_\_\_\_ Ms \_\_\_\_\_ Mstr. \_\_\_\_\_  
Social Security No. \_\_\_\_\_  
Home Telephone \_\_\_\_\_  
Business Address \_\_\_\_\_  
Business Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
E-mail \_\_\_\_\_

Spouse/Parent's Name \_\_\_\_\_  
 Same as above  
Residence - Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employed By \_\_\_\_\_  
Present Position \_\_\_\_\_

Spouse/Parent's Title: Mr. \_\_\_\_\_ Mrs. \_\_\_\_\_ Miss \_\_\_\_\_ Ms \_\_\_\_\_ Mstr. \_\_\_\_\_  
Social Security No. \_\_\_\_\_  
Home Telephone \_\_\_\_\_  
Birth Date \_\_\_\_\_  
Business Address \_\_\_\_\_  
Business Phone \_\_\_\_\_

Name of Nearest Relative \_\_\_\_\_  
Residence - Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship \_\_\_\_\_  
Telephone \_\_\_\_\_

Do you have dental insurance that may cover any part of our services?

PRIMARY

SECONDARY

Name of Employee \_\_\_\_\_  
Name of Dental Ins. Co: \_\_\_\_\_  
Group No. \_\_\_\_\_ Phone#: \_\_\_\_\_  
Date of Birth of Subscriber: \_\_\_\_\_

Name of Employee \_\_\_\_\_  
Name of Dental Ins. Co: \_\_\_\_\_  
Group No. \_\_\_\_\_ Phone#: \_\_\_\_\_  
Date of Birth of Subscriber: \_\_\_\_\_

If dual coverage, please answer both questions for both policies.

Social Security Number of Subscriber: \_\_\_\_\_

### Release and Assignment:

I hereby authorize the release of any information including the diagnosis, records of any treatments, or examinations rendered to my insurance company to facilitate the billing and reimbursement to the doctor of insurance benefits to which I am entitled.

Before, during, or after treatment this office may take photos of teeth to aid in diagnosis and treatment planning. They may also be used for consultation with other dentists, specialists, or dental laboratories, and may be used for continuing education purposes. (For which patient confidentiality is always maintained). I give my consent for these photos.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_  
or Patient's guardian if minor

Signature of Insured \_\_\_\_\_ Date \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

### OFFICE POLICIES

**APPOINTMENT:** Once you have made an appointment, remember this time is reserved for you. We try our best to stay on schedule. However, when an emergency arises, we may be delayed and we'll try to reach you at home. Please reciprocate by being on time for your appointments and canceling in advance, any appointments you are unable to keep. A charge may be made for missed or broken appointments with less than 48 hours notice.

**BILLING:** A 1.5% service charge will be added to all accounts after 60 days. This represents an annual rate of 18%.

**INSURANCE:** Your insurance coverage is a contract between you and your insurance company to help you meet dental expenses. It is not possible for us to provide service on the basis that the insurance will pay all charges, as coverage varies. We will file your forms promptly. However, we request that you pay your insurance co-payment when treatment is rendered. The fact that we do not write or administer your dental benefit plan makes it impossible for us to assure any payment for treatment. Ultimately you are financially responsible for all charges, whether or not paid by insurance.

I have read and agree to the policies listed above.

Signature of responsible party \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date of last dental exam: \_\_\_\_\_

Primary reason for today's visit \_\_\_\_\_

Date of last medical exam: \_\_\_\_\_

### MEDICAL HISTORY

- 1. AIDS/HIV Yes No
- 2. Alcoholism Yes No
- 3. Artificial Heart Valves Yes No
- 4. Artificial Joints Yes No
- 5. Asthma Yes No
- 6. Bleeding Problems Yes No
- 7. Cancer Yes No
- 8. Chemotherapy Yes No
- 9. Congenital Heart Defects Yes No
- 10. Dementia/Alzheimers Yes No
- 11. Diabetes Yes No
- 12. Emphysema Yes No
- 13. Fibromyalgia Yes No
- 14. Gastric Reflux Yes No
- 15. Glaucoma Yes No
- 16. Heart Murmur Yes No
- 17. Heart Attack or Stroke Yes No
- 18. Hepatitis Type \_\_\_\_\_ Yes No
- 19. High Blood Pressure Yes No
- 20. Kidney Problems Yes No
- 21. Liver Problems Yes No
- 22. Mitral Valve Prolapse Yes No
- 23. Pacemaker Yes No
- 24. Periodontal Disease Yes No
- 25. Radiation Treatment Yes No

- 26. Respiratory Disease Yes No
- 27. Rheumatoid Arthritis Yes No
- 28. Thyroid Problems Yes No
- 29. Tuberculosis Yes No
- 30. TMJ Disorder Yes No
- 31. Other: \_\_\_\_\_
- Pregnant Yes No
- Nursing Yes No
- Taking Birth Control Pills Yes No
- Smoke or chew tobacco Yes No

Have you ever taken Fosamax, Actonel, Boniva, Reclast, or Didronel for Osteoporosis  
 Yes No

Have you ever been treated with IV Aredia, Zometa, or Bonafos for chemotherapy  
 Yes No

Have you ever taken the diet drug Fen-Phen  
 Yes No

Physician Name \_\_\_\_\_

Physician Number \_\_\_\_\_

### MEDICAL ALLERGIES (please circle)

- Codeine \_\_\_\_\_ Sulfa \_\_\_\_\_ Penicillin \_\_\_\_\_
- Local Anesthetic \_\_\_\_\_ Latex \_\_\_\_\_ Other \_\_\_\_\_

### MEDICATIONS (including herbal supplements)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that I have filled out this form to the best of my knowledge. I understand that this information is extremely important to allow my dentist to make treatment planning decisions on my behalf. I will not hold my dentist, or his staff, responsible for any decisions they make based on mistakes that I may have made on this form.

Signature of Patient/Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_

Signature of Dentist \_\_\_\_\_

Date \_\_\_\_\_

### Dental Staff only

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Updates: Pt. Signature \_\_\_\_\_

Pt. Signature \_\_\_\_\_

Pt. Signature \_\_\_\_\_

Dr. Signature \_\_\_\_\_ Date \_\_\_\_\_

Dr. Signature \_\_\_\_\_ Date \_\_\_\_\_

Dr. Signature \_\_\_\_\_ Date \_\_\_\_\_