



Henry H. Chu, D.D.S., P.A
Victor A. Parra, D.D.S.
 15900 La Cantera Parkway, Suite 20250
 San Antonio, TX 78256-2512
La Cantera Dental – Phone 210-877-0000 Fax 210-877-0010
Bandera Dental Care – Phone 210-684-8033 Fax 210-684-8056

Thank You for Selecting Our Dental Team

To help us meet and exceed your healthcare needs, please fill out this form completely.
 If you would like assistance or have any questions, please ask us and we will be happy to help.

Patient Information (Confidential)

Date _____

Name _____ Preferred Name _____

Please Check Appropriate Box: Minor Single Married Separated Divorced Widowed

Birthdate _____ SS#/SIN _____ Driver's License # _____

Address _____ City/State/Zip _____

Email _____ Home # _____ Work # _____ Ext _____

Fax # _____ Cell # _____

If Student: School/College _____ City/State/Zip _____ PT FT

Patient or Patient/Guardian Employer _____ Work # _____

Employer Address _____ City/State/Zip _____

Spouse or Parent/Guardian Name _____ Employer _____ Work# _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone # _____

Payment is due when services are rendered. For your convenience, we offer the following methods of payment. Please check your preferred option: Cash Personal Check Visa/Mastercard CareCredit

Responsible Party (If Minor or Other Than Patient)

Name of Person Responsible for this Account _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Driver's License # _____

Address _____ City/State/Zip _____

Email _____ Home # _____ Work # _____ Ext _____

Fax # _____ Cell # _____ Financial Institution _____

Employer _____ Work # _____ Our Current Patient? Yes No

Insurance Information *Please be advised: we only file with your primary dental insurance company.

Name of Subscriber _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Employer: _____

Employer Address _____ City/State/Zip _____

Insurance Co. Name: _____ Group/Plan # _____ Member ID _____

Effective Date _____ Annual Max. _____ Annual Deductible _____ Remaining Annual Max. _____



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Patient Medical History

Physician _____ Physician's Phone # _____

Date of Last Exam _____ Patient Height _____ Patient Weight _____

- | | | | | | |
|---|-----|----|--|-----|----|
| 1. Are you under medical treatment now? | Yes | No | 10. Are you allergic to or have you had any reactions to the following? | | |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? | Yes | No | Local Anesthetics (e.g. Novocain) | Yes | No |
| If yes, please explain: _____ | | | Penicillin or any other Antibiotics | Yes | No |
| 3. Are you taking any medication(s) including non-prescription medicine? | Yes | No | Sulfa Drugs | Yes | No |
| If yes, what medication(s) are you taking? _____ | | | Barbiturates | Yes | No |
| 4. Have you ever taken Fen-Phen/Redux? | Yes | No | Sedatives | Yes | No |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medication containing bisphosphonates? | Yes | No | Iodine | Yes | No |
| 6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? | Yes | No | Aspirin | Yes | No |
| 7. Do you use tobacco? | Yes | No | Any Metals (e.g. nickel, mercury, etc.) | Yes | No |
| 8. Do you use controlled substances? | Yes | No | Latex Rubber | Yes | No |
| 9. Are you wearing contact lenses? | Yes | No | Other: _____ | | |
| | | | 11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | Yes | No |
| | | | 12. Women only: | | |
| | | | Are you pregnant? | Yes | No |
| | | | Are you nursing? | Yes | No |
| | | | Are you taking oral contraceptives? | Yes | No |

Do you or have you had any of the following?			Thyroid Problems	Yes	No	Stroke	Yes	No
High Blood Pressure	Yes	No	Heart Disease	Yes	No	Hay Fever/Allergies	Yes	No
Heart Attack	Yes	No	Cardiac Pacemaker	Yes	No	Tuberculosis	Yes	No
Rheumatic Fever	Yes	No	Angina	Yes	No	Radiation Therapy	Yes	No
Swollen Ankles	Yes	No	Emphysema	Yes	No	Glaucoma	Yes	No
Fainting/Seizures	Yes	No	Cancer	Yes	No	Recent Weight Loss	Yes	No
Asthma	Yes	No	Arthritis	Yes	No	Liver Disease	Yes	No
Low Blood Pressure	Yes	No	Joint Replacement/Implant	Yes	No	Heart Trouble	Yes	No
Epilepsy/Convulsions	Yes	No	Hepatitis/Jaundice	Yes	No	Respiratory Problems	Yes	No
Leukemia	Yes	No	Sexually Transmitted Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Diabetes	Yes	No	Stomach Troubles/Ulcers	Yes	No	Other: _____		
Kidney Disease	Yes	No	Chest Pains	Yes	No			
AIDS or HIV Infection	Yes	No	Easily Winded	Yes	No			

Patient Dental History

Name of Previous Dentist/Location _____ Date of Last Exam _____

Previous Dentist Location _____ Date of Last Cleaning _____

- | | | | | | |
|--|-----|----|---|-----|----|
| Do your gums bleed while brushing or flossing? | Yes | No | Do you have frequent headaches? | Yes | No |
| Are your teeth sensitive to hot or cold liquids/foods? | Yes | No | Do you clench or grind your teeth? | Yes | No |
| Are your teeth sensitive to sweet or sour liquids/foods? | Yes | No | Do you bite your lips or cheeks frequently? | Yes | No |
| Do you feel pain on any of your teeth? | Yes | No | Have you ever had any difficult extractions in the past? | Yes | No |
| Do you have any sores or lumps in or near your mouth? | Yes | No | Have you ever had prolonged bleeding after extractions? | Yes | No |
| Do you have any head, neck or jaw injuries? | Yes | No | Have you had any orthodontic treatment? | Yes | No |
| Have you ever experienced any of the following problems in your jaw? | | | Do you wear dentures or partials? | Yes | No |
| Clicking | Yes | No | If yes, date of placement _____ | | |
| Pain (joint, ear or side of face) | Yes | No | Have you ever received oral hygiene instructions regarding the care of your teeth and gums? | Yes | No |
| Difficulty in opening or closing | Yes | No | Do you like your smile? | Yes | No |
| Difficulty in chewing | Yes | No | | | |

I certify that I have read and understand that the above information to the best of my knowledge. The information above has been accurately provided. I understand that providing incorrect information can be dangerous to my health. I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to patient during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist of dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature (Patient's Parent/Guardian if under 18): _____ Date: _____



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Smile Assessment

Patient Name _____

Date _____

1) On a scale of 1-10 how do you rate your smile?

Please circle - 1 being very unhappy, 10 being very happy



2) Please check the following statements, if any, which apply to you:

- I wish my teeth were whiter.
- I wish my teeth were straighter.
- I wish the gaps between my teeth were smaller.
- I wish I had a wider smile.
- I think my gums show too much when I smile.
- I am unhappy with the shape of my teeth.
- I do not smile because of my teeth.
- Other _____

We are now pleased to offer Noviclear[®], the latest in custom clear aligners to straighten your teeth. We are also excited to introduce Rejuvenate[®], a natural, organic in-office whitening system to complete your perfect smile. Let us know if you are interested in learning more. We will be happy to determine if you are a candidate for these reasonably priced treatments.



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Appointment Cancellation Policy Agreement

We are committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. **Please call us by noon on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by noon on Friday.** If prior notification is not given, you will be charged \$50 for the missed appointment.

Patient Signature (Patient's Parent/Guardian if under 18)

Date

Patient Consent for Use of Email and Text Communications

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at the email address provided to you. Please remember, however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communication could be four to forty-eight hours or more. The service provider could delay message delivery. Should you require urgent or immediate action, this medium is not appropriate.

When sending email, please put the subject of your message in the subject line so that we can process your email more efficiently. Also, be sure to put your name and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the reply feature.

Communication relating to the diagnosis and treatment will be filed in your dental record. This office is dedicated to keeping your dental record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

I understand that this office will not be responsible for information loss or delay to breaches in confidentiality that are due to technical factors beyond this office's control. HIPAA guidelines recommend secure email for all protected information. In order to facilitate communications between doctors and patients, it is sometimes more convenient to use non protected, unencrypted email, voicemail, phone messages and text messaging. By signing below, you agree to waive your HIPAA privacy rights to facilitate communications between you and your doctors. Please do not send personal information such as credit card information, sensitive health data, personal identification numbers, etc... Please limit messages to those subjects you would not object to if they became public. For example, requests for medication refills, postoperative instructions or general questions about treatment.

I consent and agree to the above email and text policy.

By signing below, you are agreeing that we may send dental treatment related correspondence to you via email and text, and that we may respond to your emails and texts to us via email and text.

Patient Signature (Patient's Parent/Guardian if under 18)

Date



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Notice of Privacy Practices Consent

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restrictions, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient Signature (Patient's Parent/Guardian if under 18) Date

If signed by patient representative, state relationship to patient _____

Photographic/Video Release

In connection with dental/medical services and/or treatment rendered, I give permission for photographs/videos to be taken, with the following stipulations:

- 1. The photographs/video shall be made with the consent or by request of a member to the professional staff under such conditions and to such times as he/she may specify.
2. The photographs/videos shall be made by a dentist, professional photographer or technician under his/her direction.
3. The photographs shall be used for dental/medical records. If in the judgement of a member of the professional staff, science or education would be benefited by their use in the forms of slides, video, they may also be used for those purposes. Further, photographs may be published separately or in connection with each other in professional journals, textbooks, websites or television.
4. For marketing and/or commercial purposes, the photographs/videos shall be used for but not limited to Facebook, Instagram, Twitter, web and print materials
5. Photographs may be modified or retouched in any way the professional staff considers desirable.
6. I have read and understood the above photographic/video release information.

Printed Name of Patient

Patient Signature (Patient's Parent/Guardian if under 18) Date

Photographed by Date