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 to update your information on file.
If you would like assistance or have any questions, please ask us and we will be happy to help.

Patient Information Update (Confidential)

Date_____

Name _____ Preferred Name _____

Address _____ City/State/Zip_____

Email _____ Home # _____ Work # _____ Ext _____

Fax # _____Cell # _____

Person to Contact in Case of Emergency _____ Phone # _____

Dental Insurance Company*: _____

If dental insurance is new or has changed, please update below.

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

Name of Subscriber _____

Birthdate _____ SS#/SIN _____ Relationship to Patient _____

Employer: _____

Employer Address _____ City/State/Zip_____

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
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No
   If yes, please explain: _____
3. Are you taking any medication(s) including non-prescription medicine? Yes No
   If yes, what medication(s) are you taking? _____
4. Have you ever taken Fen-Phen/Redux? Yes No
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medication containing bisphosphonates? Yes No
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? Yes No
7. Do you use tobacco? Yes No
8. Do you use controlled substances? Yes No
9. Are you wearing contact lenses? Yes No
10. Are you allergic to or have you had any reactions to the following?
    - Local Anesthetics (e.g. Novocain) Yes No
    - Penicillin or any other Antibiotics Yes No
    - Sulfa Drugs Yes No
    - Barbiturates Yes No
    - Sedatives Yes No
    - Iodine Yes No
    - Aspirin Yes No
    - Any Metals (e.g. nickel, mercury, etc.) Yes No
    - Latex Rubber 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?

High Blood Pressure	Yes	No	Thyroid Problems	Yes	No	Stroke	Yes	No
Heart Attack	Yes	No	Heart Disease	Yes	No	Hay Fever/Allergies	Yes	No
Rheumatic Fever	Yes	No	Cardiac Pacemaker	Yes	No	Tuberculosis	Yes	No
Swollen Ankles	Yes	No	Angina	Yes	No	Radiation Therapy	Yes	No
Fainting/Seizures	Yes	No	Emphysema	Yes	No	Glaucoma	Yes	No
Asthma	Yes	No	Cancer	Yes	No	Recent Weight Loss	Yes	No
Low Blood Pressure	Yes	No	Arthritis	Yes	No	Liver Disease	Yes	No
Epilepsy/Convulsions	Yes	No	Joint Replacement/Implant	Yes	No	Heart Trouble	Yes	No
Leukemia	Yes	No	Hepatitis/Jaundice	Yes	No	Respiratory Problems	Yes	No
Diabetes	Yes	No	Sexually Transmitted Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Kidney Disease	Yes	No	Stomach Troubles/Ulcers	Yes	No			
AIDS or HIV Infection	Yes	No	Chest Pains	Yes	No	Other: _____		
			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
- Are your teeth sensitive to hot or cold liquids/foods? Yes No
- Are your teeth sensitive to sweet or sour liquids/foods? Yes No
- Do you feel pain on any of your teeth? Yes No
- Do you have any sores or lumps in or near your mouth? Yes No
- Do you have any head, neck or jaw injuries? Yes No
- Have you ever experienced any of the following problems in your jaw?
  - Clicking Yes No
  - Pain (joint, ear or side of face) Yes No
  - Difficulty in opening or closing Yes No
  - Difficulty in chewing Yes No
- Do you have frequent headaches? Yes No
- Do you clench or grind your teeth? Yes No
- Do you bite your lips or cheeks frequently? Yes No
- Have you ever had any difficult extractions in the past? Yes No
- Have you ever had prolonged bleeding after extractions? Yes No
- Have you had any orthodontic treatment? Yes No
- Do you wear dentures or partials? Yes No
  If yes, date of placement _____
- Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No
- Do you like your smile? 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:** _____

DENTAL GROUP

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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