Henry H. Chu, D.D.S., P.A & Associates
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

COVID-19 Questionnaire

1. Have you tested positive for COVID-19?
☐ Yes ☐ No

2. Have you been tested for COVID-19 and are awaiting results?
☐ Yes ☐ No

3. Do you have any of the following respiratory symptoms? Fever, Sore Throat, Cough, Shortness of Breath
☐ Yes ☐ No

4. Have you recently lost your sense of smell or taste?
☐ Yes ☐ No

5. Do you have any GI symptoms? Diarrhea? Nausea?
☐ Yes ☐ No

6. Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days? ☐ Yes ☐ No

7. Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?
☐ Yes ☐ No

8. Have you traveled outside the United States by air or cruise ship in the past 14 days?
☐ Yes ☐ No

9. Have you traveled within the United States by air, bus or train within the past 14 days?
☐ Yes ☐ No

Trace Instructions:
Please contact our office if you experience COVID-19 symptoms within 14 days after dental appointment.

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

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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
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:** ______________

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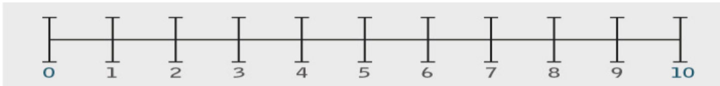
Smile Assessment

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 also excited to introduce Venus White®, our 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, it prevents another patient from being seen. Please give a 48-hour notice if you wish to cancel or reschedule your appointment. **To cancel or reschedule a *Monday* appointment, please call our office by noon on *Friday*.** If appointment cancelled or rescheduled within 48 hours of appointed time or prior notification is not given, a $50 fee for the missed appointment will apply.

____ ______________________
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.

____ ______________________
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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