



**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



*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

***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\*: \_\_\_\_\_

\_\_\_\_\_ There have been no changes to my dental insurance since I last provided plan information.  
Initials

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

***\*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 \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Group/Plan # \_\_\_\_\_ Member ID \_\_\_\_\_ Effective Date \_\_\_\_\_

Annual Max. \_\_\_\_\_ Annual Deductible \_\_\_\_\_ Remaining Annual Max. \_\_\_\_\_



**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

### Patient Medical History

Physician \_\_\_\_\_ Physician's Phone # \_\_\_\_\_

Date of Last Exam \_\_\_\_\_ Patient Height \_\_\_\_\_ Patient Weight \_\_\_\_\_

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

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

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

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: \_\_\_\_\_



*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

### ***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.

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

\_\_\_\_\_  
Date



*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

## 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<sup>®</sup>, 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.**