Alamo Springs Dental Returning Patient Form

Welcome Back! Please Provide Updated/New Information Below.

Date:___________________________

Patient Name: **Last:_________________________ First:__________________________________ MI:_______**

Best Phone Number :_____________________ **Email:** ____

Any Changes to your home address? **YES** or **NO**, If yes please list new address below :
Address____State___________Zip___________

Do you have new dental insurance? YES or NO, If yes, please **Name and Policy #**___________________________________
Employer Name:___________________________

1. It is **OK** to be contacted about appointments and leave messages in regards to treatment via (***CIRCLE ALL THAT APPLY***):

   HOME PHONE   CELL PHONE   FAX   TEXT MESSAGE   EMAIL

2. I **allow** you to give my clinical information to or answer questions from (***check all that apply***):

☐ Spouse ☐Parent ☐Child ☐Other (specify)______________________ ☐No One

I, ________________________________, hereby acknowledge that I have received/read a copy of Alamo Springs Dental's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice. (See the Privacy Notice laminated pages at the end of patient forms or framed at the front desk.)

______________________________   ___________________________

Sign Name Above   *Date*

Are you having any dental pain today?   **YES**   **NO**

Please Circle Your Dental Concerns:

Pain   **Cavities**   **Teeth Cleaning**

Teeth Whitening   **Missing Teeth**   **Jaw Pain**

Braces   **Teeth Sensitivity**   **Other:_______________________**

Medical History Update

1. Have there been any changes in your medical history? **YES** OR **NO**
2. Please List any **new medications** or attach a page separately:
   ____
   ____
3. Have you had any **new operations** since your last visit? If yes, please list below:____
   ____
4. List **any** Allergies :
   ____
   ____

I certify that I have read and understand this form. I will not hold Alamo Springs Dental doctors or staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I understand the cancellation policy, and that appointments cancelled without 24hr notice may cause my account to incur a $50 fee. I will notify my dentist of any changes in my health.

_______________________________________   ____

Signature of Patient/Legal Guardian   ***Doctor Signature after Review***

Alamo Springs Dental Medical History

Due to concerns about the spread of viruses like the Flu (Influenza Virus) and the Coronavirus (COVID-19), we have added a few questions that we are asking **all** patients to help keep our patients, team members and doctors informed and safe as possible. Please respond to the questions below.

1. Do you have acute respiratory illness **including frequent cough/sneezing, fever, and/or shortness of breath**?

   YES **NO**

2. Have you had a recent **trip to one of the states or countries that the CDC has listed as high risk for COVID-19 within the past 14 days**?

   YES **NO** **Unsure**

If you are **unsure**, where have you traveled in the past 14 days?____

____

3. Have you had close contact with someone who is under investigation for coronavirus infection?

   YES **NO**

Patient Name PRINTED: I, ___________________________________ have answered these questions to the best of my ability.

Patient Signature: ____ Date: _____________________________

Find more information at: WWW.CDC.GOV/covid19 www.dshs.texas.gov/coronavirus

Thank you for your cooperation and patience at this time as we do our best to keep our patients and staff safe.