OUR PROMISE

We promise a gentle touch, a comfortable environment, and a genuine smile.
We look forward to seeing you!

SEAN B. ABIDIN, DDS & VANESSA M. CAO, DDS

SMILE

PATIENT INFORMATION

Name	Date of Birth	SS#	
Address	City	State	Zip
Home Phone	Cell Phone	Email Address	
Check appropriate boxes: ❑ Male ❑ Female ❑ Married ❑ Single ❑ Child ❑ Widowed ❑ Divorced ❑ Other:			
If Student, Name of School/College	City	State	❑ Full Time ❑ Part Time
Employer	City	State	Phone
Emergency Contact	Home Phone	Cell Phone	
Whom may we thank for referring you?			

DENTAL INSURANCE

Name of Insured	Relationship to Patient	SS#/Subscriber ID	
Date of Birth	Employer	Phone	
Insurance Carrier	Group Number	Phone	
Insurance Carrier Address	City	State	Zip

Is the patient covered by a Secondary Dental Plan? If YES, please complete the following:

Name of Insured	Relationship to Patient	SS#/Subscriber ID	
Date of Birth	Employer	Phone	
Insurance Carrier	Group Number	Phone	
Insurance Carrier Address	City	State	Zip

Dental Claim Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Drs. Abidin and Cao, all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

Drs. Abidin and Cao may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits.

I understand that I am financially responsible for all charges, whether or not paid by insurance.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative — Date

Privacy Practices Acknowledgment

I, _____ have been offered a copy of this office's Notice of Privacy Practices.
(Print Name)

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative — Date

Although we primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions honestly and completely.

SEAN B. ABIDIN, DDS & VANESSA M. CAO, DDS

SMILE

DENTAL HISTORY

Date of Last Dental Care	Date of Last Dental X-Rays	Former Dentist Name

Are you having or have you had any of the following:

- ❑ Pain in Teeth
- ❑ Sensitivity to Sweets
- ❑ Sensitivity when Biting
- ❑ Sensitivity to Hot
- ❑ Sensitivity to Cold
- ❑ Broken Teeth or Fillings
- ❑ Periodontal or Gum Disease
- ❑ Bleeding Gums
- ❑ Loose Teeth
- ❑ Bad Breath
- ❑ Food Collection Between Teeth
- ❑ Difficult/Surgical Extractions
- ❑ Frequent Headaches
- ❑ Grinding or Clenching
- ❑ Clicking or Jaw Popping
- ❑ Head, Neck, or Jaw Injuries
- ❑ Sores or Growths in or Around Mouth
- ❑ Orthodontic Treatment

Are you having or have you had any other concerns with your mouth and/or teeth? _____

Have you ever had instructions on the correct method of brushing your teeth? ❑ Yes ❑ No

Have you ever had instructions on the care of your gums? ❑ Yes ❑ No

How Do You Like Your Smile?

Rate your smile: ***HELP It!*** ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ***LOVE It!***

What, if anything, would you change about your smile? _____

Would you like more information on:

- ❑ Bleaching
- ❑ Implants
- ❑ Veneers/Cosmetic Dentistry
- ❑ Oral Cancer
- ❑ Other: _____

MEDICAL HISTORY

Physician's Name	Date of Last Visit	Phone
How long ago was your blood pressure checked?	Approximate Reading:	
Are you on a special diet? ❑ Yes ❑ No If yes, explain:		
Do you, or have you taken any of the drugs collectively referred to as "Phen-Fen" or Redux? ❑ Yes ❑ No If yes, when?		

Have you ever had a Blood Transfusion? ❑ Yes ❑ No If yes, please provide date: _____

Do you smoke cigarettes or use smokeless tobacco? ❑ Yes ❑ No If you used to, but quit, how long ago did you quit? _____

Do you use controlled substances? ❑ Yes ❑ No If you used to, but quit, how long ago did you quit? _____

Please Continue on Back

SEAN B. ABIDIN, DDS & VANESSA M. CAO, DDS

SMILE

Do you have, or have you ever, any of the following?

Yes	No		Yes	No		Yes	No	
❑	❑	AIDS/HIV Positive	❑	❑	Emphysema	❑	❑	Pain in Jaw Joints
❑	❑	Alzheimer's Disease	❑	❑	Epilepsy/Seizures	❑	❑	Parathyroid Disease
❑	❑	Anaphylaxis	❑	❑	Excessive Bleeding	❑	❑	Psychiatric Care
❑	❑	Anemia	❑	❑	Excessive Thirst	❑	❑	Radiation Treatments
❑	❑	Angina	❑	❑	Fainting/Dizziness	❑	❑	Recent Weight Loss
❑	❑	Arthritis	❑	❑	Frequent Diarrhea	❑	❑	Renal Dialysis
❑	❑	Artificial Heart Valves	❑	❑	Frequent Headaches	❑	❑	Respiratory Disease
❑	❑	Artificial Joints	❑	❑	Genital Herpes	❑	❑	Rheumatic Fever
❑	❑	Asthma	❑	❑	Glaucoma	❑	❑	Rheumatism
❑	❑	Blood Disease	❑	❑	Gout	❑	❑	Scarlet Fever
❑	❑	Breathing Problems	❑	❑	Hay Fever	❑	❑	Shingles
❑	❑	Bruise Easily	❑	❑	Heart Attack/Failure	❑	❑	Sickle Cell Disease
❑	❑	Cancer	❑	❑	Heart Disease	❑	❑	Sinus Trouble
❑	❑	Chemical Dependency	❑	❑	Heart Murmur	❑	❑	Sleep Apnea
❑	❑	Chemotherapy	❑	❑	Heart Pace Maker	❑	❑	Spina Bifida
❑	❑	Chest Pains	❑	❑	Hemophilia	❑	❑	Stomach/Intestinal Disease
❑	❑	Circulatory Problems	❑	❑	Hepatitis A	❑	❑	Stroke
❑	❑	Cold Sores/Fever Blisters	❑	❑	Hepatitis B or C	❑	❑	Swelling of Limbs
❑	❑	Congenital Heart Disorder	❑	❑	Herpes	❑	❑	Thyroid Disease
❑	❑	Convulsions	❑	❑	High Blood Pressure	❑	❑	Tonsillitis
❑	❑	Cortisone Treatments	❑	❑	History of Bisphosphonates	❑	❑	Tuberculosis
❑	❑	Cough, Persistent	❑	❑	Liver Disease	❑	❑	Tumors/Growths
❑	❑	Cough up Blood	❑	❑	Low Blood Pressure	❑	❑	Ulcers
❑	❑	Diabetes	❑	❑	Lung Disease	❑	❑	Venereal/STD's
❑	❑	Easily Winded	❑	❑	Osteoporosis/ Osteopenia	❑	❑	Yellow Jaundice

Have you had any other serious illness or injury not listed above? If yes, please explain: _____

WOMEN

Are you pregnant or trying to get pregnant? ❑ Yes ❑ No

Taking Oral Contraceptives? ❑ Yes ❑ No

Nursing? ❑ Yes ❑ No

ALLERGIES

❑ Acrylic ❑ Aspirin ❑ Barbiturates ❑ Codeine ❑ Latex ❑ Local Anesthetics ❑ Metal ❑ Penicillin ❑ Sulfa

❑ Other: _____

List ALL Prescription Drugs you currently take:	List any Herbal Remedies, Multi-Vitamins, Supplements, or Over-the-Counter Drugs you take more than 2X per week:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian

Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message
□ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____ _____
Signature of Privacy Officer