

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:	<input type="checkbox"/> Male	<input type="checkbox"/> Married	<input type="checkbox"/> Child	<input type="checkbox"/> Divorced
	<input type="checkbox"/> Female	<input type="checkbox"/> Single	<input type="checkbox"/> Widowed	<input type="checkbox"/> Other:
If Student, Name of School/College		City	State	<input type="checkbox"/> Full Time <input type="checkbox"/> 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.



DENTAL HISTORY

Date of Last Dental Care	Date of Last Dental X-Rays	Former Dentist Name
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Are you having or have you had any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain in Teeth | <input type="checkbox"/> Periodontal or Gum Disease | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Sensitivity to Sweets | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Grinding or Clenching |
| <input type="checkbox"/> Sensitivity when Biting | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Clicking or Jaw Popping |
| <input type="checkbox"/> Sensitivity to Hot | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Head, Neck, or Jaw Injuries |
| <input type="checkbox"/> Sensitivity to Cold | <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> Sores or Growths in or Around Mouth |
| <input type="checkbox"/> Broken Teeth or Fillings | <input type="checkbox"/> Difficult/Surgical Extractions | <input type="checkbox"/> 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!!* ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *LOVE!!*

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
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How long ago was your blood pressure checked?	Approximate Reading:
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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



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

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

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

WOMEN		ALLERGIES		
Are you pregnant or trying to get pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Acrylic	<input type="checkbox"/> Codeine	<input type="checkbox"/> Metal
Taking Oral Contraceptives?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Latex	<input type="checkbox"/> Penicillin
Nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Sulfa
		<input type="checkbox"/> 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



Appointment and Payment Agreement

Payment at the time of services is expected. Prepayment is expected for appointments scheduled over an hour. For your convenience, we accept Care Credit, Credit or Debit cards. Our office will be happy to submit claims to your insurance company. **A service charge of 1.5% per month will be added to all balances 60 days and older.** The annual rate of the service charges is 18%. I understand that Sean B. Abidin, DDS & Vanessa M. Cao, DDS will make every effort to collect from my insurance company. I hereby authorize Sean B. Abidin, DDS & Vanessa M. Cao, DDS to furnish information to insurance carriers concerning my treatment and I hereby assign to the dentist all payments for dental services covered by insurance for services rendered to me or my dependents.

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Since appointment times at Sean B. Abidin, DDS & Vanessa M. Cao, DDS are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In an effort to decrease unnecessary costs related to staffing and supplies and in order to contain our costs and continue to provide you with affordable fine dentistry for your entire family, we maintain a No-Show/Cancellation Policy for all of our patients. To promote efficient access to our clinic, we require that any appointment that is no longer needed or is unable to be kept, **must be cancelled at least two business days in advance of the appointment.** Cancellations must be made during normal business hours on workdays at least two full business days before the scheduled appointment. Cancellations must be done over the phone by speaking directly to one of our dental professionals. Patients will not be charged if cancellation is made two business days before their appointment. Since we certainly understand that illness or other problems can occur (sometimes without any warning), we will not charge you for your first missed or cancelled appointment. In the event a second appointment is missed or cancelled with less than two business days' notice, or no notice, a **\$50 charge will be billed.** If a third no-show or same day cancellation occurs, we reserve the right to terminate the doctor-patient relationship as well as another \$50 charge.

This policy is in effect for all appointments at our office. Please acknowledge that you have had the opportunity to review this policy by signing below.

The undersigned hereby authorizes the release or any information relating to all claims for benefits submitted on behalf of myself, spouse, or dependents including the assignment of benefits payable to Sean B. Abidin, DDS & Vanessa M. Cao, DDS. I further agree and acknowledge that my signature on this document authorizes my dentist to submit for myself, spouse, or dependents all insurance claims forms necessary for submission and that I will be bound by this signature as though the undersigned had personally signed the particular claim form.

Past due balances are subject to a late payment of 1.5% per month (18% annual).

Relationship to Patient: _____

Signature: _____ Response 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:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

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

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> 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:

- | | |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the above (opt out) |
| <input type="checkbox"/> Email | |

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