OUR PROMISE

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

SEAN ABIDIN, DDS & VANESSA 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 ABIDIN, DDS & VANESSA 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: _____

Name (print) _____

SEAN ABIDIN, DDS & VANESSA CAO, DDS

SMILE

Patient Name (print)_____

MEDICAL HISTORY

Physician's Name	Date of Last Visit	Phone

Please mark your response to indicate if you have/had any of the following diseases or problems. Please explain any marked conditions.

- ❑ AIDS/HIV
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina/Chest Pains
- ❑ Arthritis (rheumatoid/osteo)
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back problems
- ❑ Blood Disorder
- ❑ Blood Thinner
- ❑ Blood Transfusion
- ❑ Cancer/Chemo/Radiation
- ❑ Cold Sores/Fever Blisters
- ❑ Controlled Substance Use
- ❑ Diabetes (Type I or Type II)
- ❑ Eating Disorders
- ❑ Emphysema/COPD
- ❑ Epilepsy/Seizures
- ❑ Fainting/Dizziness
- ❑ Fibromyalgia
- ❑ GERD/heartburn
- ❑ Glaucoma
- ❑ Headaches/Migraines
- ❑ Heart Attack/Failure
- ❑ Heart Disease
- ❑ Heart Pacemaker
- ❑ Hepatitis (Type _____)
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ History of Bisphosphonates
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Lupus
- ❑ Osteopenia/Osteoporosis
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Respiratory Disease
- ❑ STDs
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Sleep Apnea
- ❑ Steroid Treatments
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tobacco Use (Type _____)
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Ulcers

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
If yes, Due Date _____

Taking Oral Contraceptives? ❑ Yes ❑ No

Nursing? ❑ Yes ❑ No

ALLERGIES

- ❑ Acrylic
- ❑ Codeine
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Metal
- ❑ NSAIDs
- ❑ Penicillin
- ❑ Clindamycin
- ❑ Seasonal
- ❑ Other: _____

List ALL Prescription Drugs you currently take:	List any Herbal Remedies, Vitamins, Supplements, or Over-the-Counter Drugs you take:

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

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

SMILE

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: ____ /____ /_____

450 Alkyre Run Drive, Suite 260, Westerville, OH 43082 | 614.882.9828 PH | 614.839.0393 FX

SEAN ABIDIN, DDS & VANESSA CAO, DDS

SMILE

I, _____

First Name Last Name DOB

consent to have my/my dependent's dental work and/or photographs/videos posted within the dental practice of Sean B. Abidin, DDS & Vanessa M. Cao, DDS and on the office website, social media accounts, video or slide show presentations, print ads and all other marketing or advertising efforts that promote the dental practice.

_____ _____

Patient Name (printed) Patient Signature

_____ _____

Parent/Guardian Name (printed) Parent/Guardian Signature

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