COVEDALE
DENTAL STUDIO

4998 Glenway Ave
Cincinnati, OH 45238
P: 513-251-5500

New Patient Intake Form

Are you filling this form out for yourself or someone else? _____

1) Patient Information

Full Name: _____
Preferred Name: _____
Date of Birth: _____ **Gender:** ☐ Male ☐ Female ☐ Other
Social Security #: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Phone (Mobile): _____
Phone (Home): _____
Email: _____

Is it okay if we **text** you appointment reminders? _____
Is it okay if we **email** you appointment reminders? _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

How did you hear about us? _____
Who can we thank for referring you? _____

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2) Emergency Contact

Name: _____
Relationship: _____
Phone Number: _____

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3) Insurance Information

Primary Insurance: _____
Subscriber Name: _____
Subscriber DOB: _____ **Relationship to Patient:** _____
Member ID/Policy #: _____
Group #: _____
Employer: _____
☐ Check if you have secondary insurance – we will collect details at your visit.

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4) Medical History

Primary Care Physician Name and contact: _____
Date of Last Visit: _____
Preferred pharmacy/phone number: _____
Please check if you have or have had any of the following:

☐ Heart Condition ☐ High Blood Pressure ☐ Diabetes ☐ Asthma ☐ Sleep Apnea
☐ Kidney Disease ☐ Liver Disease ☐ Bleeding Disorder ☐ Cancer
☐ Stroke ☐ Thyroid Issues ☐ Respiratory Issues ☐ Epilepsy/Seizures
☐ Artificial Joints ☐ Anxiety/Depression ☐ Autoimmune Disease
☐ HIV/AIDS ☐ Hepatitis A/B/C ☐ Tuberculosis (TB) ☐ Osteoporosis
☐ Artificial (Prosthetic) Heart valve
☐ Other: _____

Have you ever taken or are you currently taking any bisphosphonate medications (such as Fosamax, Actonel, Boniva, Reclast, Zometa)**?** ☐ Yes ☐ No
If yes, list medication: _____

Have you ever taken or are you currently taking any blood thinner medications (such as Warfarin, Xarelto, Pradaxa, Plavix, Heparin, and Aspirin)**?** ☐ Yes ☐ No
If yes, list medication: _____

Do you use GLP-1 Glucagon-Like Peptide-1 medication? ☐ Yes ☐ No

Are you currently under a physician's care? ☐ Yes ☐ No
If yes, explain: _____

List any medications you are currently taking, including over the counter medication, vitamins/herms, and/or supplements:

_____
_____
_____
_____

Do you smoke or vape? ☐ Yes ☐ No
Do you use any recreational drugs? ☐ Yes ☐ No. If yes, what substance: _____
Do you drink alcohol? ☐ Yes ☐ No
Are you pregnant or nursing? ☐ Yes ☐ No ☐ N/A. Please specify: _____
Allergies (check all that apply):

☐ Latex ☐ Penicillin ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Metals
☐ Aspirin ☐ Codeine ☐ Other: _____

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5) Dental History

Reason for today's visit (exam, cleaning, pain/discomfort, etc):_____

Can you provide more details: _____

_____

When was your last dental visit and what was done at that appointment? _____

_____

Last time dental x-rays were taken: _____

Is it hard to open your mouth? ☐ Yes ☐ No

Does it hurt to chew, bite, or swallow? ☐ Yes ☐ No

Are your teeth sensitive to hot or cold? ☐ Yes ☐ No

Do your gums bleed when brushing or flossing? ☐ Yes ☐ No

Have you ever had periodontal (gum) treatments, like scaling and root planing? ☐Yes ☐No

Do you have, or have you ever had, any sores or growths in your mouth? ☐ Yes ☐ No

Do you grind/clench your teeth? ☐ Yes ☐ No

Does your jaw click, pop, or hurt? ☐ Yes ☐ No

Do you have earaches or neck pains? ☐ Yes ☐ No

Does dental treatment make you nervous? ☐ Yes ☐ No

Have you ever experienced any of these sleep related breathing disorders?

☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep ☐ Sleep apnea

Have you ever had serious injury to your head or mouth? ☐ Yes ☐ No

If yes, please describe what happened and how it happened: _____

_____

Have you ever had problems with dental treatments in the past? ☐ Yes ☐ No

If yes, please describe what happened: _____

_____

Have you ever had a reaction to or problem with dental anesthesia? ☐ Yes ☐ No

If yes, please describe what happened: _____

_____

How often do you brush? _____

How often do you floss? _____

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Are you unhappy with your smile? ☐ Yes ☐ No IF yes, please mark all that apply:

☐ Color of your teeth ☐ Shape of your teeth ☐ Position of your teeth

☐ Other. Please describe: _____

Have you ever had any of the following:

☐ Orthodontic Treatment (Braces)

☐ Periodontal/Gum Treatment; Deep Cleanings

☐ Extractions

☐ Implants or Dentures

☐ Cosmetic Dentistry (veneers, whitening, etc.)

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6. Acknowledgments & Consent

I certify that the information provided is accurate and complete to the best of my knowledge.

Patient/Guardian Name (Printed): _____

Signature: _____

Date: _____

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Financial Agreement

Thank you for choosing Covedale Dental Studio for your dental care. We are committed to helping you achieve and maintain a healthy smile. Please understand that payment for services is considered a part of your treatment. The following financial policies are designed to promote clear communication and mutual understanding. We ask that you read and sign this agreement prior to treatment.

Authorization To Discuss Financial Matters

To ensure clear and accurate communication regarding your financial responsibilities, please inform our office if you have a medical Power of Attorney (POA) or if there is another individual authorized to discuss your financial matters on your behalf.
If you would like us to discuss your financial details with someone other than yourself, you will be required to sign a HIPAA Authorization Form listing their name(s) to ensure compliance with patient privacy regulations.
It is your responsibility to notify our office of any such authorization prior to your appointment.

Insurance

Please remember that your dental insurance policy is a contract between you and your insurance company. Our office is not a party to that contract. As a courtesy, we may assist with billing and submit pre-treatment estimates at your request. However, we cannot guarantee coverage or payment from your insurer.
It is your responsibility to verify your coverage, benefits, and limitations. You are responsible for any charges not covered by your plan, including deductibles, co-pays, and services your insurer may deem not medically necessary or out-of-network.

Payment Policy

Payment is due at the time of service unless prior arrangements have been made. We accept cash, checks, debit cards, and credit cards.

- **Full payment** is required at the time of treatment for patients without insurance.
- **Estimated co-pays and deductibles** are due at the time of treatment for patients using insurance.
- For larger treatment plans, we may require a **50% deposit** before scheduling in order to reserve time and order materials specific to your care.
- A **3% surcharge** will apply to all credit card transactions. This fee does not apply to payments made by **cash, check, Health Savings Account cards, or debit card.**

Unpaid Balances

Any balance older than 90 days will be subject to a **2.0% monthly interest** (24% APR). If an account is sent to collections, the patient (or responsible party) will be liable for all related fees, including but not limited to attorney fees and court costs.

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Refund Policy

Our office does not offer refunds for services already rendered. This includes exams, x-rays, cleanings, emergency treatment, and any portion of treatment that has been initiated.
For prepaid treatment (such as clear aligners, major restorative work, or multi-visit procedures), refunds may be considered on a **case-by-case basis** if treatment has not yet been started or irreversible steps taken (e.g., digital impressions, lab submissions, ordering of aligners or prosthetics). Any refund will be subject to:

- **Deductions for costs already incurred**, such as lab fees, materials, and chair time
- A **minimum administrative fee of $75**
- Refunds issued only to the original payor and payment method, and processed within **30 days** of request

Refunds will not be granted for dissatisfaction related to esthetics when treatment was provided according to the signed treatment plan and consent forms. We are happy to address concerns through revisions or continued care.

Missed Appointment Policy

We reserve your appointment time exclusively for you. To avoid a missed appointment charge, cancellations must be made **at least 48 business hours** in advance.

- **Hygiene appointments**: $50 cancellation fee
- **Doctor visits under 2 hours**: $75 fee
- **Doctor visits 2 hours or longer**: $100/hour cancellation fee

We appreciate your cooperation in helping us provide timely care to all our patients.

By signing below, I acknowledge that I have read, understood, and agree to the financial policies of Covedale Dental Studio.

Patient/Guardian Name (Printed): _____

Signature: _____

Date: _____

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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have been offered a copy of the Notice of Privacy Practices for Covedale Dental Studio.

I understand that this notice describes how my health information may be used and disclosed and how I can access this information.

I understand that:

- A printed copy of the Notice of Privacy Practices is available at the front desk
- The Notice of Privacy Practices is also be available on the practice's website

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Substance Use Disorder (SUD) Records

I understand that certain health information related to substance use disorder diagnosis, treatment, or referral is protected under federal law (42 CFR Part 2), in addition to HIPAA.

I understand that:

- This information may not be used or disclosed without my written authorization except as permitted by law
- Some disclosures may be subject to restrictions on redisclosure
- I have the right to revoke authorization for disclosure of this information in writing, as permitted by law

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Patient/Guardian Name (Printed): _____

Patient/Guardian Signature: _____

Date: _____

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General Informed Consent for Dental Treatment

We are committed to providing you with the highest standard of care. Before beginning any dental treatment, it is important that you understand the potential risks, benefits, and alternatives associated with your care. Please read the following information carefully and ask any questions you may have before signing.

I authorize dental treatment including necessary or advisable examination, radiographs (x-rays), diagnostic aids or local anesthesia.

In general terms, dental treatment may include but is not limited to one or a number of the following:

- Administration of local anesthesia
- Cleaning of the teeth and application of topical fluoride
- Scaling and root planing with local anesthesia
- Application of sealants to the grooves of the teeth
- Treatment of diseased or injured teeth with dental restorations
- The replacement of missing teeth with a dental prosthesis (crown, bridges, dentures, partials, etc.)
- Treatment of diseased or injured oral tissues via removal/extraction (hard and/or soft)
- Treatment of malposed (crooked) teeth and/or developmental abnormalities.
- Treatment of the canal or pulp chamber that lies in the middle of the tooth and its root also known as “endodontic” therapy or root canal

Risks of Dental Procedures in General

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain; infection; swelling; bleeding; sensitivity; numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth; thrombophlebitis (inflammation to a vein); reaction to injections; change in occlusion (biting); muscle cramps and spasms; tempromandibular jaw (TMJ) joint difficulty; loosening of teeth or restoration(s) in teeth; injury to other tissues; referred pain to the ear, neck and head; nausea; allergic reactions; itching; bruises; delayed healing; sinus complications and further surgery. Medications and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give my permission to the dentist to make any/all changes and additions as necessary.

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Fillings
I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

Crowns (Caps), Bridges and Onlays
I understand that sometimes it is not possible to match the color of artificial teeth with natural teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized the final opportunity to make changes in my new crown or bridge (including shape, fit, size and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size or color will incur an additional charge.

Alternative Treatment
I understand that I have the right to choose, on the basis of adequate information, from alternate treatment plans that meet professional standards of care.

Use of Dental Materials
I understand that dental materials used in restorations (e.g., fillings, crowns) may contain substances such as metals, ceramics, or composite resins. A Dental Materials Fact Sheet is available for review at:
https://www.dbc.ca.gov/formspubs/pub_dmfs2004.pdf
A printed copy is available at the front desk upon request.

Patient Acknowledgment and Consent

By signing below, I confirm that:

- I have read and fully understand the information above.
- I have had the opportunity to ask questions and all of my questions have been answered.
- I voluntarily consent to receive dental care at Covedale Dental Studio as recommended by my provider.
- I understand that **no guarantees have been made** regarding the outcome of treatment.

Patient or Guardian Name (Printed): _____

Signature: _____

Date: _____

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Dental Photography Consent and Authorization Form

Patient Name: _____
Date of Birth: _____
Date: _____

Important Notice About Clinical Photography

As part of providing high-quality dental care, Covedale Dental Studio routinely takes photographs, X-rays, and digital images of your teeth, gums, and surrounding oral structures. These images are a required part of your clinical record and are used for:

- Diagnosis and treatment planning
- Monitoring oral health and treatment progress
- Documentation in your confidential patient chart

These clinical images are necessary for your care and are not optional. They are kept private and handled in accordance with HIPAA and applicable privacy laws.

Optional Authorization for Educational & Marketing Use

In addition to clinical documentation, we may request permission to use certain images for:

- Educational purposes (e.g., lectures, case studies, professional training)
- Marketing and promotional materials (e.g., website, social media, brochures, advertisements)

Please select one:

☐ **YES, I authorize** Covedale Dental Studio to use my images for educational and marketing purposes as described above.

☐ **NO, I do NOT authorize** the use of my images for any purpose outside of my confidential clinical record.

If You Consent to Optional Use

If you select "YES" above, you acknowledge and agree that:

- Your participation is voluntary, and you will not receive financial compensation now or in the future.
- Images may be edited, cropped, or modified, but will be used in a professional manner.
- Your identity will not be disclosed (e.g., no full name or identifying details) without separate written consent.
- Images may be used in printed and digital formats.
- Once published—especially online—images may be publicly accessible and may not be fully retractable.

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You waive the right to inspect or approve the final materials and release Covedale Dental Studio, its staff, and affiliates from any claims related to the use of these images, including claims of privacy, publicity, or defamation.
This authorization applies to all current and future media formats.

Authorization

Patient or Guardian Name (Printed): _____
Signature: _____
Date: _____

If Patient is a Minor

Parent/Guardian Name: _____
Relationship to Patient: _____
Signature: _____
Date: _____