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
☐ 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
☐ Other: _____

Have you ever taken or are you currently taking any bisphosphonate medications (such as Fosamax, Actonel, Boniva, Reclast, Zometa)?

☐ Yes ☐ No

Are you currently under a physician's care? ☐ Yes ☐ No
If yes, explain: _____
List any medications you are currently taking:

_____
_____
_____
_____

Do you take blood thinners? ☐ Yes ☐ No
Do you smoke or vape? ☐ Yes ☐ No
Do you use any recreational drugs? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No
Are you pregnant or nursing? ☐ Yes ☐ No ☐ N/A
Allergies (check all that apply):

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

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5) Dental History

Reason for today's visit (exam, cleaning, etc): _____
Can you provide more detail: _____
_____

When was your last dental visit? _____
Last dental cleaning: _____

Do you experience dental anxiety? ☐ Yes ☐ No
Have you ever had a bad experience at the dentist? ☐ Yes ☐ No
Have you ever had a bad reaction to dental anesthetic? ☐ Yes ☐ No
Have you had any complications following dental work? ☐ Yes ☐ No
Are your teeth sensitive to hot or cold? ☐ Yes ☐ No
Do your gums bleed when brushing or flossing? ☐ Yes ☐ No
Do you grind/clench your teeth? ☐ Yes ☐ No
Have you ever been diagnosed with periodontal (gum) disease? ☐ Yes ☐ No
How often do you brush? _____
How often do you floss? _____
Do you like your smile? ☐ Yes ☐ No

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.)

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, or debit card.**

Unpaid Balances

Any balance older than 90 days will be subject to a **1.0% monthly interest** (12% 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

This notice describes how your health information may be used and disclosed and how you can access this information. Please read it carefully.

At Covedale Dental Studio, your privacy is a top priority. The **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** requires that all health care providers maintain the privacy of your **protected health information (PHI)**—whether spoken, written, or electronic. This law also grants you specific rights regarding how your PHI is used and disclosed.

Permitted Uses and Disclosures of PHI

Without your specific written authorization, we may use or disclose your PHI for the following purposes:

1. **Treatment**
   We may use your PHI to provide, coordinate, or manage your dental care.
   Example: cleanings, exams, x-rays, fillings, crowns, etc.
2. **Payment**
   We may use your PHI to obtain payment for services, verify coverage, and perform billing tasks.
   Example: submitting a claim to your dental insurance.
3. **Health Care Operations**
   We may use your PHI for practice operations such as quality assessment, audits, staff training, and customer service.
   Example: reviewing documentation protocols.

Additional Uses and Disclosures

We may also use or disclose your PHI to:

- Remind you of appointments (by phone, text, email, or mail)
- Discuss treatment options or share relevant health-related services
- Communicate with family or individuals involved in your care
- Comply with federal, state, or local law
- Respond to court orders, subpoenas, or law enforcement requests
- Assist with public health reporting or oversight
- Collaborate with coroners, funeral directors, or organ procurement organizations
- Prevent serious threats to your health or the safety of others
- Assist military and national security operations, if required
- Comply with workers' compensation programs

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Your Rights Regarding PHI

You have the right to:

- Request restrictions on how your PHI is used or disclosed (though we are not required to agree)
- Request confidential communications (e.g., using an alternate address or phone number)
- Access and obtain a copy of your health records
- Request an amendment to your records if you believe they are incorrect or incomplete
- Receive an accounting of certain disclosures we have made (outside of treatment, payment, or operations)
- Receive a printed copy of this notice upon request

Changes to This Notice

We reserve the right to change this Notice at any time. Updates will be posted in our office with the effective date. You may request a written copy of the revised Notice at any time.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with:

U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Phone: 877-696-6775

Covedale Dental Studio will not retaliate against you for filing a complaint.

Acknowledgment

I acknowledge that I have received and reviewed a copy of the Notice of Privacy Practices.

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.

Examinations and X-rays

I understand that a comprehensive dental exam may require the use of dental radiographs (x-rays) in order to accurately diagnose and develop a treatment plan. These x-rays are considered essential to properly evaluate my dental health.

Medications, Anesthetics, and Sedation

I understand that the use of local anesthetics, antibiotics, analgesics (pain relievers), and other prescribed or administered medications carry potential risks, including but not limited to:

- Allergic reactions (e.g., rash, swelling, itching, vomiting, or anaphylaxis)
- Drowsiness, dizziness, or reduced coordination
- Interaction with alcohol or other substances
- Reduced effectiveness of oral contraceptives when using antibiotics

I agree **not to drive or operate machinery** for at least 12 hours following sedation or until I feel fully recovered. I also understand that not taking medications as prescribed may lead to continued infection, delayed healing, or complications.

Changes in Treatment Plan

I understand that during treatment, it may be necessary to modify the original treatment plan due to unforeseen conditions (e.g., discovering the need for a root canal after starting a filling). I authorize the dental team to make appropriate adjustments in my treatment as clinically necessary.

Temporomandibular Joint (TMJ) Symptoms

I understand that opening the mouth for extended periods during treatment may aggravate or cause symptoms such as popping, clicking, pain, or locking of the jaw. These symptoms are usually temporary. If they persist, I may require referral to a specialist at my own expense.

Nerve and Tissue Injury

I understand that dental procedures may carry the risk of damage to oral or facial nerves, which can result in numbness or tingling of the lips, tongue, cheeks, or other tissues. These effects are generally temporary, but in rare cases, may be permanent. While every effort will be made to avoid complications, **no guarantees can be made** regarding treatment outcomes.

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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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General Photography & Image Release Consent

I hereby authorize **Covedale Dental Studio** (hereafter referred to as "the Practice") to take and use photographs, video recordings, or other digital images of me and/or my likeness for the purposes of:

- Clinical documentation and dental records
- Educational use (e.g., presentations, case studies, continuing education)
- Marketing and promotional materials, including but not limited to website content, social media, printed brochures, and advertisements

I understand that:

- My participation is voluntary, and I will receive no financial compensation now or in the future for the use of these images.
- These images may be edited, copied, published, or distributed for lawful purposes, and may appear in printed or digital formats.
- Any identifying information (such as my full name) will not be used unless I provide separate written consent.
- Once published, especially online, the images may be publicly accessible and not revocable.

I hereby waive any right to inspect or approve the finished product or any accompanying written material. I also release and hold harmless the Practice, its employees, contractors, and any third parties involved in the production or publication of these materials from any and all claims, demands, or causes of action that I may now or hereafter have, including any claims for libel, invasion of privacy, or violation of the right of publicity.
This release is binding and extends to all media, formats, and channels now known or hereafter developed.

Authorization

Patient or Guardian Name (Printed): _____

Signature: _____

Date: _____

If patient is a minor:

Name of Parent/Guardian: _____

Relationship to Patient: _____