Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____ Birth Date: _____

Social Security #: _____ Driver's Lic#: _____

Phone (Home): _____ (Cell): _____ (Work): _____ Ext: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Email Address _____

Emergency Contact: _____ Phone _____

How were you referred to our office? _____

Health Information

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer/tumor
- ❑ Radiation or Chemotherapy
- ❑ Heart ailment or chest pain, heart attack, stroke
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve in the body
- ❑ High or low blood pressure
- ❑ Pacemaker/Heart surgery
- ❑ Asthma/Tuberculosis or other lung problems
- ❑ Kidney disease/Dialysis
- ❑ Hepatitis A B or C/Other liver disease/Jaundice
- ❑ Alcoholism
- ❑ Head Injury requiring hospitalization
- ❑ Diabetes Type I or Type II
- ❑ Neurologic condition/Parkinsons
- ❑ Epilepsy, seizures, or fainting spells/dizziness
- ❑ Autism
- ❑ Emotional condition/Anxiety or Depression/Nervousness
- ❑ Arthritis or Rheumatoid Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive/Venereal Disease
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders/Blood Transfusion
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Infective Endocarditis/Congenital heart defect not repaired

- ❑ Sinus Trouble/Hayfever/Seasonal allergies or hives
- ❑ Thyroid Disease
- ❑ Glaucoma
- ❑ Stomach problems/Ulcers
- ❑ Respiratory Problems/Emphysema

Are you allergic to, or have you reacted adversely to any of the following? PLEASE CIRCLE

Latex materials
Penicillin, Sulfa or other antibiotics
Local anesthetics ("Novocaine")
Codeine
Barbiturates, sedatives, or sleeping pills
Aspirin
Other: _____

Are you taking any of the following? PLEASE CIRCLE

ADHD/ADD Medications
Aspirin/Anticoagulants (blood thinners)
Antibiotics or sulfa drugs
High blood pressure medicine
Antidepressants/Sedatives/Relaxers
Marijuana/Cocaine/Meth/MDMA/Heroin or other recreational drugs
Insulin, Orinase, or other diabetes drug
Nitroglycerin
Cortisone/Prednisone or other steroids
Radiation or Chemotherapy
Osteoporosis (bone density) medicine/Bisphosphonates
Pre Medication prior to dental appointments
Herbal Supplements/Vitamins: Please specify
_____
Other Medications: _____

Women: Pregnant? Yes No or Maybe
Expected delivery date _____
Taking hormones or contraceptives? Yes or No
Breast Feeding? Yes No

Do you smoke or use chewing tobacco? ❑ yes ❑ no How often? _____ How many years? _____

Do you have any current dental concerns? _____

- What would you like to change about your smile? : _____

Cosmetic Dentistry Treatment

Have you considered or do you have questions about the following:

Smile Makeovers	Injectables
❑ Zirconia Crown	❑ Botox
❑ Porcelain Veneer	❑ Juvederm
❑ Teeth Whitening	
❑ Invisalign	

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain:_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you taking any MEDICATIONS? ☐ Yes ☐ No
  Please list: _____
- Are you under the care of a physician? ☐ Yes ☐ No If yes, please explain:_____
- Name of Physician: _____ Phone:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Consent for Services

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of Doctor

Cedar Village Dentistry
Thomas R. Dooley, D.M.D
General Dentist
5212 Cedar Village Drive
Mason, Ohio 45040
Phone: 513.770.4370
Fax: 513.770.4325
www.cedarvillagedentistry.com

HIPAA- Acknowledgement of Receipt

Notice of Privacy Practices

Printed Patient Name:_____

Patient Date of Birth:_____

I hereby acknowledge that I have received the HIPAA Notice of Privacy Practice document.

Signature of patient/legal guardian:_____ Date:_____

Printed name of patient/legal guardian:_____

Please list any person by name that you allow us to share your private information with:

1._____

2._____

3._____

4_____

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Late Policy:

Please note that we value your time in our office and strive our best to seat you promptly at your appointment time.
Please value our time as well and arrive for your appointment 10 minutes in advance to allow for any necessary paperwork.

If you arrive to your appointment 15 minutes late, you will be asked to kindly reschedule.

Print Name:_____

Signature:_____ Date:_____

Patient Financial and Insurance Benefits Agreement for Cedar Village Dentistry

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in dentistry. We are also committed to providing you with up to date information and education and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate excellent service to you, while minimizing our administrative costs.

Your cost for treatment is due at the time service is provided. Our office accepts cash, personal checks, and most major credit cards. Outside financing is available through Care Credit. In addition, we offer our Cedar Village Dentistry Membership Plan to help offset some of the costs.

If you are a patient with dental insurance, we require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

Although we are willing to complete insurance forms and submit a claim on your behalf, we do not accept responsibility for the outcome transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and facilitate payment to our office. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for treatment.

Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance.

All changes you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract.

Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to sort out any questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any dispute over payments made or not made by your insurance company.

Your estimated co-payment for treatment, which is the amount not covered by your insurance, is due at the time we provide services. The co-payment is only an estimate and may be found to be insufficient after review by the insurance company.

Returned checks will incur a $30 insufficient funds fee. Balances older than 30 days may be subject to finance charges. In addition, all professional courtesies applied to the account will be removed before being sent to a collection agency if balances go over 90 days and payment arrangements have not been met.

Cancellation policy- If unable to keep a dental appointment kindly give 48 hour advance notice. We reserve the right to charge for missed appointments and insufficient notice of cancellation.

Print Name _____ Date _____

Signature of Patient/Responsible Party _____