303 Bancario Rd. Ste. 7, Marion, AR 72364 | 870-739-8799

New Patient Intake

Patient, contact, insurance, dental concerns, and acknowledgment

Patient Information

Legal name ______________________ Preferred name ______________________

Date of birth __________ Age ______ Social Security # __________ ☐ Male ☐ Female ☐ Other

Home address ______________________

City ______________ State ______ ZIP ______

Cell phone __________ Home phone __________ Email address __________

Employer __________ Occupation __________ Best time/method to reach you __________

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Who may we thank for referring you? ______________ Previous dentist / last visit date ______________

Other family members seen in this office ______________________

Responsible Party / Spouse Information, if different from patient

Name ______________ Relationship __________ Phone __________

Employer ______________ Work phone __________ SS# / driver license # __________

Emergency Contact

Name ______________ Relationship __________ Phone __________

Address / city / state / ZIP ______________________

Insurance

Primary coverage

Company __________ Member / policy ID __________ Group # ______ Insurance phone __________

Subscriber name __________ Subscriber DOB ______ Relationship ______ Subscriber SS# __________

Subscriber employer ______________ Insurance address ______________________

Secondary coverage, if any

Company __________ Member / policy ID __________ Group # ______ Insurance phone __________

Subscriber name __________ Subscriber DOB ______ Relationship ______ Subscriber SS# __________

Dental Concerns

Main reason for today's visit ______________________

☐ Pain ☐ Broken tooth ☐ Swelling ☐ Cleaning ☐ Cosmetic ☐ Other

☐ I have been advised to take antibiotics before dental treatment

☐ I am currently in pain

☐ I have jaw joint soreness, popping, or locking

☐ My gums bleed when brushing or flossing

Dental health: ☐ Good ☐ Fair ☐ Poor

Floss: ☐ Yes ☐ No

Times/day brush __________

Health History

Medical conditions, medications, allergies, and safety information

Patient name ______________________ **Date** ______________

Current Health Information

Question	Yes	No	
Under a physician's care now?	☐ Yes	☐ No	**Explain**
Hospitalized or major surgery?	☐ Yes	☐ No	**Explain**
Serious head, neck, or jaw injury?	☐ Yes	☐ No	**Explain**
Taking medications, pills, injections, vitamins, or supplements?	☐ Yes	☐ No	**Use medication list**
Taken Fosamax, Boniva, Actonel, or similar bone medication?	☐ Yes	☐ No	**When**
Use tobacco or nicotine?	☐ Yes	☐ No	**Type / amount**
Use alcohol, recreational drugs, or controlled substances?	☐ Yes	☐ No	**Explain**
Special diet or medical restriction?	☐ Yes	☐ No	**Explain**

For women: ☐ Pregnant ☐ Trying to become pregnant ☐ Nursing ☐ Taking oral contraceptives

Allergies

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic	☐ Metals
☐ Latex	☐ Local anesthetic	☐ Sulfa drugs	☐ Other	

Describe allergy reactions or other medication sensitivities

Medical Conditions - Check any that apply now or have applied in the past

☐ AIDS/HIV	☐ Alzheimer's disease	☐ Anemia	☐ Angina/chest pain	☐ Artificial heart valve
☐ Artificial joint	☐ Asthma	☐ Blood disease	☐ Blood transfusion	☐ Cancer
☐ Chemotherapy	☐ Cold sores/fever blisters	☐ Congenital heart disorder	☐ Convulsions/seizures	☐ Diabetes
☐ Dizziness/fainting	☐ Drug addiction	☐ Easily winded	☐ Emphysema/COPD	☐ Excessive bleeding
☐ Frequent cough	☐ Frequent diarrhea	☐ Frequent headaches	☐ Glaucoma	☐ Hay fever/allergies
☐ Heart attack/failure	☐ Heart murmur	☐ Pacemaker	☐ Heart trouble/disease	☐ Hemophilia
☐ Hepatitis A/B/C	☐ Herpes	☐ High blood pressure	☐ High cholesterol	☐ Hives or rash
☐ Hypoglycemia	☐ Irregular heartbeat	☐ Kidney problems	☐ Leukemia	☐ Liver disease
☐ Low blood pressure	☐ Lung disease	☐ Mitral valve prolapse	☐ Osteoporosis	☐ Jaw joint pain
☐ Parathyroid disease	☐ Psychiatric care	☐ Radiation treatment	☐ Recent weight loss	☐ Renal dialysis
☐ Rheumatic fever	☐ Rheumatism	☐ Scarlet fever	☐ Shingles	☐ Sickle cell disease
☐ Sinus trouble	☐ Spina bifida	☐ Stomach/intestinal disease	☐ Stroke	☐ Swelling of limbs
☐ Thyroid disease	☐ Tonsillitis	☐ Tuberculosis	☐ Tumors/growths	☐ Ulcers
☐ Venereal disease	☐ Yellow jaundice			

Other serious illness, condition, or concern not listed above

Additional comments

Patient Confirmation

I have answered these questions to the best of my knowledge. I understand that health information helps the dental team provide safer care, and I will tell the office about changes in my health or medications.

Patient signature ______________________ **Date** ______________

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Medication List

Prescription, over-the-counter, vitamins, and supplements

Patient name ______________________

Physician / prescribing doctor ______________________

Please list all medications, including prescriptions, over-the-counter medications, vitamins, herbal products, and supplements. Use additional paper if needed.

#	Medication or supplement	Reason taken	Dose / strength	How often	Prescribing doctor
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					

Preferred pharmacy name and phone ______________________

Medication allergies or side effects ______________________

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General Dental Treatment Consent

Information about common risks, choices, and authorization for care

Patient name ______________________________

Date ______________________________

Dental care can involve exams, x-rays, local anesthetic, medications, fillings, crowns, extractions, dentures, periodontal care, root canal treatment, and other procedures. This form gives a general overview. Specific procedures may require additional discussion or consent.

1. Examination and x-rays

Images may be recommended to evaluate teeth, bone, existing restorations, infections, or other conditions that cannot be fully seen during a visual exam.

2. Medications, anesthetic, and sedation

Dental medications may cause side effects such as numbness, drowsiness, stomach upset, allergic reaction, or reduced effectiveness of oral contraceptives when antibiotics are used. Patients should not drive or operate machinery if they are impaired by medication.

3. Changes during treatment

Conditions found during treatment may require a change in the original plan. The dental team will explain significant changes when possible and may recommend referral or additional care.

4. Jaw joint and muscle symptoms

Keeping the mouth open during dental treatment can temporarily increase jaw soreness, popping, locking, or muscle discomfort, especially in patients with a history of TMJ symptoms.

5. Fillings and restorations

Teeth may be sensitive after restorations. New fillings, crowns, veneers, bonding, bridges, or other dental work may need adjustment, repair, replacement, or additional treatment in the future.

6. Extractions

Removal of teeth may involve soreness, swelling, bleeding, dry socket, infection, sinus involvement, nerve changes, or jaw complications. Alternatives may include no treatment, fillings, crowns, root canal therapy, periodontal care, or referral when appropriate.

7. Crowns, bridges, veneers, and bonding

Color, shape, bite, and fit are discussed before final placement when possible. Artificial materials may not perfectly match natural teeth, and future repair or replacement may be needed.

8. Dentures and partial dentures

Removable appliances may require adjustment, relining, repair, or replacement. Changes in gum tissue and bone can affect fit over time.

9. Root canal treatment

Root canal therapy is intended to help save a tooth, but success is not guaranteed. Some teeth may need retreatment, surgery, crown restoration, or extraction.

10. Periodontal treatment

Gum disease may lead to bone loss, tooth mobility, infection, and tooth loss. Long-term success depends on home care, professional cleanings, follow-up visits, and risk factors such as tobacco use.

I understand that dentistry cannot promise a specific result. I have had the opportunity to ask questions, and I authorize Wayne Cook DDS Family Dentistry to provide dental care that is discussed with me and agreed upon.

Patient / guardian signature ______________________________

Date ______________________________

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Office Policies

Scheduling, payment, nitrous oxide, and crown warranty

Patient name ______________________________ **Date** ____________________

Appointment Changes and Missed Visits

Please contact our office as soon as possible if you need to change or cancel an appointment. Appointments cancelled with less than 24 hours notice, or missed without notice, may result in a failed appointment fee. Longer appointments may involve an additional fee because more chair time has been reserved.

Initials ____________________

Repeated Failed Appointments

After three missed or failed appointments, the practice may dismiss the patient from active care. Emergency treatment and record transfer will be handled according to applicable requirements.

Initials ____________________

Payment

Payment is due when treatment is completed unless payment arrangements have been approved in advance. The office accepts major credit cards, cash, checks, and CareCredit. Patients are responsible for co-payments, deductibles, and any balance not paid by insurance.

Initials ____________________

Nitrous Oxide

Nitrous oxide may be available for selected procedures. The current fee is $30.00. Insurance may not cover nitrous oxide, and payment is due on the day of service.

Initials ____________________

Crown Warranty

For crown warranty consideration through the dental lab, patients must maintain recommended preventive care, including routine cleanings about every six months unless otherwise directed. If recommended preventive care is not maintained, the patient may be responsible for replacement costs.

Initials ____________________

Patient / responsible party signature ______________________________ **Date** ____________________

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Dental Photography and Video Consent

Use of images for records, education, and communication

Patient name ______________________________ **Date of birth** ______________

I give permission for Wayne Cook DDS Family Dentistry to take photographs and/or video of my face, jaws, mouth, and teeth before, during, or after dental care. Images may help with diagnosis, treatment planning, documentation, education, and communication.

I allow images to be used for the following purposes:

- ☐ Dental records and treatment documentation
- ☐ Consultation with dental laboratories, specialists, or other health professionals involved in my care
- ☐ Patient education, professional teaching, seminars, demonstrations, or publications
- ☐ Website, social media, printed material, or other practice marketing/education materials

If images are used outside my dental record, I understand that reasonable efforts will be made to avoid unnecessary identifying information unless I give permission. I do not expect payment or compensation for approved use of these images. I may ask the office questions before signing.

Optional limitations or comments:

____

____

____

Patient / guardian signature ______________________________ **Date** ______________

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Privacy and Communication Preferences

HIPAA acknowledgment and permission to contact you

Patient name ______________________________ **Date** ______________

Our Notice of Privacy Practices explains how protected health information may be used or shared for treatment, payment, and healthcare operations. By signing below, I acknowledge that I have been offered the opportunity to review the notice and ask questions.

I understand that:

- ☐ Health information may be used or disclosed for treatment, payment, and healthcare operations.
- ☐ The practice may update its privacy practices as allowed by law.
- ☐ I may request limits on certain uses or disclosures; the practice will follow accepted restrictions when required or agreed to.
- ☐ I may revoke consent in writing, but revocation will not affect actions already taken.
- ☐ Treatment may depend on receiving necessary consent and information.

Communication Choices

May we call, text, or email appointment reminders to you?	☐ Yes	☐ No
May we leave a brief message on voicemail or answering machine?	☐ Yes	☐ No
May we discuss dental or medical information with family members you name below?	☐ Yes	☐ No

Names of family members or individuals allowed to receive information

____

Phone numbers / relationship / limits, if any

____

Acknowledgment

I confirm that the choices above reflect my preferences. I understand that I may update these preferences in writing.

Print name ______________________________ **Date** ______________

Signature ______________________________ **Witness / staff initials** ______________