ALL INFORMATION FURNISHED ON THIS FORM IS CONFIDENTIAL

JOSEPH J CAIN DMD
208 South Vardaman Street
Wiggins Mississippi 39577
601 928 2229

WIGGINS FAMILY DENTISTRY

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Single ☐ Married ☐ Child ☐ Other_____

Social Security #: _____ **Date of Birth:** _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Email: _____

Person to contact in case of emergency: _____ Phone:_____

Health Information

Date of Last Dental Visit: _____ Reason for today's visit:_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS or HIV
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Bleeding Disorders
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Fainting
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High or Low Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Tumors
☐ Ulcers
OTHER:
☐ _____
☐ _____
☐ _____

Are you allergic to or have you ever gotten ill from any of the following? Please check those that apply:

☐ Aspirin
☐ Local Anesthetics (novocaine, etc.)
☐ Penicillin or other antibiotics
☐ Sulfa drugs
☐ Codeine
☐ Nitrous oxide (laughing gas)
☐ LATEX
OTHER:
☐ _____

Please check if you have taken or are currently taking the following:

☐ Fosamax ☐ Zometa ☐ Reclast ☐ Boniva ☐ Actonel ☐ Aredia ☐ Any Other Osteoporosis Meds:_____

- Do you smoke? __ Yes __ No
- 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 now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking any medication? ☐ Yes ☐ No
  If yes, please list all medicines: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ **Another patient, friend** ☐ **Another patient, relative**
☐ Dental Office Sign ☐ Yellow Pages ☐ Newspaper ☐ Work ☐ Other_____
Name of person or office referring you to our practice:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ **Date of Birth**: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will prepare the patients insurance forms and assist in making collections from insurance companies and will credit any such collections to the patient's account. If the insurance company does not cover 100% of the charge, the patient is responsible for the portion not covered at the time of service.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have answered all questions on this form correctly and honestly. If I ever have any change in my health or other information included in this form, I will inform the doctor at the next appointment. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent, guardian or guarantor of payment