

Welcome to our Practice!

Dr. Sonal Jain, DDS, PA
Family Dentistry
83 E. Westfield Avenue
Roselle Park, NJ 07204



Phone: (908) 245-7600

Please fill out this form. Our goal is to help you reach and maintain your dental health and enhance your smile!

Date: _____

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last _____

I prefer to be called _____

Sex: Male Female Marital status: Single Married Widowed Divorced/Separated

Birth Date: _____ / _____ / _____ Social Security #: _____

Home Address: _____

Email Address: _____

Phone number: (Circle the best number to call you)

Home: _____ Cell: _____ Work: _____ Ext: _____

Referred By: _____ Other Family members seen by us? YES NO

EMPLOYMENT INFORMATION

Employer: _____

Employer Address: _____

Occupation: _____

SPOUSE / PARENT INFORMATION

His / Her Name: _____

Birth Date: _____ / _____ / _____ Social Security #: _____

Employer: _____

EMERGENCY CONTACT INFORMATION

His / Her Name: _____

Relationship to you: _____ Phone: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance:

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ PLAN / GROUP # _____

PLAN ID # _____ Insured Name: _____

Relation _____ Date of Birth _____ / _____ / _____

(If different from patient)

Insured's Employer: _____

Employer Address: _____

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Patient Name: _____

Secondary Insurance:

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ PLAN / GROUP # _____

PLAN ID # _____ Insured Name: _____

Relation _____ Date of Birth _____ / _____ / _____

(If different from patient)

Insured's Employer: _____

Employer Address: _____

Payment is due in full at the time of service. If this office accepts my insurance, I understand that I am responsible for payment at the time of service including any co-payment and / or deductible .

I also understand that I am fully responsible for services not covered by my Dental Insurance Company.

There will be a charge of \$50 for canceling my appointment without 24 hours prior notice to the scheduled appointment time.

Signature of Patient or Parent/Guardian

INSURANCE ASSIGNMENT AND RELEASE

I authorize the payment to be made by my Insurance Company _____ directly to Dr. Sonal Jain, D.D.S., P.A.

The above named dental practice may release healthcare information (or my minor/child/dependant's) to the above named insurance company and their agents.

Signature of Patient or Parent/Guardian

MINOR / CHILD CONSENT

I am the parent, guardian or personal representative of _____ (name of Minor / child).

I do hereby authorize the dental staff to perform necessary dental services for the child named above including dental x-rays, administration of anesthesia and the dental treatment which are deemed necessary by the doctor, whether or not I am present in the treatment room when the treatment is rendered.

Signature of Parent/Guardian

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Patient Name: _____

MEDICAL HISTORY

Physician's Name: _____ Physician Phone: _____

Date of last visit: _____

Pharmacy Name: _____ Pharmacy Phone : _____

Medical conditions you are currently being treated for:

Current listing of medications (Prescription and over the counter medication)

Do you smoke or use tobacco in any form? _____

FOR WOMEN

Are you taking birth control pills? YES NO

Are you pregnant? YES NO

Are you nursing? YES NO

ALLERGY INFORMATION

Are you allergic to any of the following?

Any Medications: _____

Dental Anesthetics: _____

Jewelry / Metals: _____

Latex: _____

Other: _____

Have you ever had/have any of the following disease or medical problem?(Circle)

- | | |
|--|--|
| <input type="checkbox"/> Abnormal Bleeding / Haemorrhillia | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> High Blood Press |
| <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Hospitalized |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Artificial Bones / Jts. / Valves | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Low Bl. Pressure |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Cancer / Chemotherapy | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Psychiatric Issue |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation Tx |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Sickle Cell / Traits |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Heart Attack / Surgery | <input type="checkbox"/> Tuberculosis(TB) |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Venereal Disease |

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Patient Name: _____

Please list all surgeries with dates:

DENTAL HISTORY

Date of last dental visit: _____

Are you currently in pain? YES NO

Do you need antibiotics before dental treatment? YES NO

Have you ever had a serious/difficult problem associated with any previous dental work? YES NO

If YES, please explain:

Is there any other information we need to know prior to completing the necessary dental treatment?

Signature of Patient or Parent/Guardian

DOCTOR SIGNATURE

I have verbally reviewed the medical/dental information with the above named patient.

Initials

Date