Welcome to our Practice!

Jain Dental Studio
20 E. 40th Street, Suite 1300
New York, NY 07204

Phone: (646) 630-0808

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 Jain Dental Studio.

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, weather or not I am present in the treatment room when the treatment is rendered.

____

Signature of Parent/Guardian

Jain Dental Studio
20 E. 40th Street, Suite 1300
Roselle Park, NY 07204

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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)

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

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Patient Name:______________________________

Please list all surgeries with dates:

DENTAL HISTORY

Date of last dental visit: ____________________________________

Are your 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