Welcome to our Practice!

Dr. Sonal Jain, DDS, PA
Family Dentistry
83 F. Westfield Avenue

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 Middle Initial First Name Last I prefer to be called _____ Sex: Male Female Marital status: Single Married Midowed Divoced/Sparated Home Address: Email Address: Phone number: (Circle the best number to call you) Home: _____ Cell: ____ Work: ____ Ext: ____ Other Family members seen by us? YES NO Referred By: **EMPLOYMENT INFORMATION** Employer: Employer Address: Occupation: **SPOUSE / PARENT INFORMATION** His / Her Name: Birth Date: / / Social Security #: Employer: **EMERGENCY CONTACT INFORMATION** His / Her Name: ____ Phone: _____ Phone: ____ Relationship to you: _____ 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:

Dr. Sonal Jain, DDS, PAFamily Dentistry

83 E. Westfield Avenue Roselle Park, NJ 07204



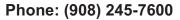
Phone: (908) 245-7600

	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:						
•	e. If this office accepts my insurance, I understand that I am responsible ervice including any co-payment and/or deductible.					
I also understand that I am fully respo	nsible for services not covered by my Dental Insurance Company.					
There will be a charge of \$50 for cance appointment time.	eling my appointment without 24 hours prior notice to the scheduled					
Signature of Patient or Parent/Guardian						
INSURA	NCE ASSIGNMENT AND RELEASE					
I authorize the payment to be made by m Dr. Sonal Jain, D.D.S.,P.A.	y Insurance Company directly to					
The above named dental practice may rele named insurance company and their agen	ase healthcare information (or my minor/child/dependant's) to the above ts.					
Signature of Patient or Parent/Guardian						
	MINOR / CHILD CONSENT					
I am the parent, guardian or person minor/child).	al representative of (name of					
	perform necessary dental services for the child named above including a and the dental treatment which are deemed necessary by the doctor, troom when the treatment is rendered.					
Signature of Parent/Guardian						

Dr. Sonal Jain, DDS, PA

Family Dentistry

83 E. Westfield Avenue Roselle Park, NJ 07204





						Patient Name:		
			M	FDICA	J	HISTORY		
Physicia	ın's Name					Physician Phone:		
							_	
Date of last visit:					Pharmacy Phone :			
	conditions you are current				-	namaey i nene :		
		_				_		
Current	listing of medications (Pre	scripti	ion and	over the	e c			
Do you s	smoke or use tobacco in a	ny for	m?					
				FOR	W	OMEN		
Are you	taking birth control pills? pregnant?		YES YES YES		NC NC)		
Are you	nursing?	Ш		_				
			ALLE	:RGY I	NI	FORMATION		
-	allergic to any of the follow	_						
						- dil		
_	u ever had/have any of the		ving ais	ease or	' m	edical problem?(Circle)		
	onormal Bleeding / Hemophil DS	ia				Herpes		
	cohol / Drug Abuse					High Blood Press HIV		
□ An	nemia			- 1		Hospitalized		
	thritis					Kidney Problems		
	tificial Bones / Jts. / Valves sthma					Liver Disease Low Bl. Pressure		
	ood Transfusion					Lupus		
□ Ca	ancer / Chemotherapy					Mitral Valve Prolapse		
	olitis					Pacemaker		
	ongenital Heart Defect abetes					Psychiatric Issue Radiation Tx		
	fficulty Breathing					Rheumatic Fever		
☐ En	mphysema			- 1		Seizures		
	pilepsy					Shingles		
	ainting Spells equent Headaches					Sickle Cell / Traits Sinus Problems		
	ancoma					Stoke		
□ Ha	ay Fever			- 1		Thyroid Problem		
	eart Attack / Surgery					Tuberculosis(TB)		
	eart Murmur epatitis					Ulcers Venereal Disease	(Page:3)	

Dr. Sonal Jain, DDS, PAFamily Dentistry

83 E. Westfield Avenue Roselle Park, NJ 07204



Phone: (908) 245-7600

Please list all surgeries with dates:						
D	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 assoc If YES, please explain:	ciated with any previous dental work? YES NO					
Is there any other information we need to know prior	r to completing the necessary dental treatment?					
Signature of Patient or Parent/Guardian						
DO	OCTOR SIGNATURE					
I have verbally reviewed the medical/dental info	ormation with the above named patient.					
Initials	Date					

Patient Name:_