Welcome to our Practice!

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

Shal Jaind.d.s.,p.A.

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

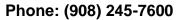
First Name	Middle Initi	al		Last	
I prefer to be called _					
Sex: Male	Female Marital status	S: Single	Married	Widowed	Divorced/Separated
Birth Date:		Social	Security #:		
Home Address:					
Email Address:					
Phone number: (Circ	cle the best number to call	you)			
Home:	Cell:	Work	« :		Ext:
Referred By:		Other	Family mem	nbers seen by	us? YES NO
	EMPLO	YMENT INFO	RMATION		
Employer:					
Employer Address: _					
Occupation:					
	SPOUSE	/ PARENT INF	ORMATIO	N	
His / Her Name:					
Employer:					
		Y CONTACT		ΓΙΟΝ	
Relationship to you:					·
Primary Insurance:	INSUR	ANCE INFOR	MATION		
•	Name:				
	Address:				
Insurance Company	pany Phone:PLAN / GROUP #				
PLAN ID #	Insured Name:				
Relation	Date	e of Birth	/	/	_
(If different from patie	•				
• •					
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 or payment at the time of service including	• •		nat I am responsible f
I also understand that I am fully responsi	ble for services not covered by my [Dental Insuranc	ce Company.
There will be a charge of \$50 for cance appointment time.		ours prior notic	ce to the scheduled
Signature of Patient or Parent/Guardian		_	
INSURA	NCE ASSIGNMENT AND RELE	ASE	
I authorize the payment to be made by to Dr. Sonal Jain, D.D.S., P.A.	my Insurance Company		directly
The above named dental practice may above named insurance company and the	·	my minor/child/	/dependant's) to the
Signature of Patient or Parent/Guardian		_	
	MINOR / CHILD CONSENT		
I am the parent, guardian or personal Minor / child).	I representative of		(name of
I do hereby authorize the dental staff to p dental x-rays, administration of anesthe doctor, whether or not I am present in the	esia and the dental treatment whi	ch are deeme	_
Signature of Parent/Guardian			

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			Patient Name:	
	M	IEDICAL	HISTORY	
Physician's Name:		F	Physician Phone:	
Date of last visit:			•	
Pharmacy Name:			Pharmacy Phone :	
Medical conditions you are cu			,	
Current listing of medications	(Prescription and	over the o		
Do you smoke or use tobacco	o in any form?			
		FOR W	OMEN	
Are you taking birth control pi	ills? 🗌 YES	□ мо)	
Are you pregnant?	☐ YES	□ NO		
Are you nursing?	YES	□ NC)	
	ALL	ERGY IN	FORMATION	
Are you allergic to any of the f	following?			
Any Medications:				
Dental Anesthetics:				
Jewelry / Metals:				
Latex:				
Other:				
Have you ever had/have any o				
☐ Abnormal Bleeding / Haer	mothillia		Herpes	
Alashal / Drug Alausa		□	High Blood Press	
☐ Alcohol / Drug Abuse ☐ Anaemia			HIV Hospitalized	
☐ Arthritis		H	Kidney Problems	
Artificial Bones / Jts. / Val	ves	□	Liver Disease	
Asthma		□	Low Bl. Pressure	
☐ Blood Transfusion☐ Cancer / Chemotherapy			Lupus Mitral Valve Prolapse	
☐ Calities Chemotherapy		H	Pacemaker	
☐ Congenital Heart Defect		□		
☐ Diabetes		П	Radiation Tx	
☐ Difficulty Breathing☐ Emphysema			Rheumatic Fever Seizures	
			Shingles	
☐ Fainting Spells		П	Sickle Cell / Traits	
☐ Frequent Headaches			Sinus Problems	
☐ Glaucoma ☐ Hay Fever			Stroke Thyroid Problem	
☐ Fainting Spells ☐ Frequent Headaches ☐ Glaucoma ☐ Hay Fever ☐ Heart Attack / Surgery ☐ Heart Murmur			Tuberculosis(TB)	
			Ulcers	
☐ Henatitis		П	Venereal Disease	(Page: 3

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Patient Name:		
Please list all surgeries with dates:		
DEN	NTAL HISTORY	
Date of last dental visit:		
Are your currently in pain? TYES NO	_	
Do you need antibiotics before dental treatment? \prod Y	ES NO	
Have you ever had a serious/difficult problem associate If YES, please explain:	ed with any previous dental work? TYES NO	
Is there any other information we need to know prior to	completing the necessary dental treatment?	
Signature of Patient or Parent/Guardian		
DOCT	TOR SIGNATURE	
I have verbally reviewed the medical/dental inform	nation with the above named patient.	
Initials	 Date	