Welcome to our Practice!

Jain Dental Studio
20 E. 40th Street, Suite 1300
New York, NY 10017

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: _____

_____

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

Phone: (646) 630-0808

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

Phone: (646) 630-0808

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

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

Phone: (646) 630-0808

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