PARK AVENUE DENTAL
Cosmetic, Implant & Family Care
160 Oaktree Avenue
South Plainfield, NJ 07080
(908) 757 - 3200

DR. MINNI SHARMA, DMD

Providing Healthy Smiles for All Ages

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First M MM DD YY

☐Male ☐Female ☐Married ☐Single ☐Child ☐Other _____

Social Security #: _____ Birth Date: _____ E-Mail: _____
MM DD YY

Phone (Home): _____ Mobile/Cell: _____ Work: _____ Ext. _____

In case of Emergency, contact Name: _____ Phone: _____ Relation: _____
First Last

Address: _____
Street Apartment #

_____
City State Zip Code

RESPONSIBLE PARTY INFORMATION

Name: _____ Social Security #: _____
Last First M

Sex: _____ Date of Birth: _____ Relationship to Patient: _____
MM DD YY

Address: _____
Street Apartment #

_____
City State Zip Code

INSURANCE INFORMATION

PRIMARY COVERAGE

Name of Insured: _____ Social Security #: _____
Last First M

Sex: _____ Date of Birth: _____ Relationship to Patient: _____
MM DD YY

Insured's Employer Name: _____ Group # _____

Insurance Plan Name and Telephone: _____

SECONDARY COVERAGE

Name of Insured: _____ Social Security #: _____
Last First M

Sex: _____ Date of Birth: _____ Relationship to Patient: _____
MM DD YY

Insured's Employer Name: _____ Group # _____

Insurance Plan Name and Telephone: _____

REFERRAL INFORMATION

How did you hear about our practice?

☐Doctor Referral ☐Friend/Relative ☐Radio/TV Ad ☐Mailer ☐Internet Search

☐Insurance ☐Other: _____

Name of referring person: _____
Last First M

HEALTH INFORMATION

Previous Dentist: _____

Date of Last Dental Visit: _____ **Date of Last X-rays:** _____

Reason for This Visit: _____

Have you ever had any of the following? Please check all that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chest Pain
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Defect
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prelapse (MVP)
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due:_____
- ☐ Prescribed Weight Loss Med.
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rhaumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco Usage
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Antibiotics Allergy
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy
- ☐ Other Anesthetic Allergy

OTHER:

- ☐ _____
- ☐ _____
- ☐ _____

Have you ever had any complications following dental treatment(s)? ☐**Yes** ☐**No**

If yes, please explain: _____

Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐**Yes** ☐**No**

If yes, please explain: _____

Are you now under the care of a physician? ☐**Yes** ☐**No**

If yes, please explain: _____

Name of Physician: _____ **Phone:** _____

Do you have any health problems that need further clarification? ☐**Yes** ☐**No**

If yes, please explain: _____

Are you taking any medications? Please List: _____

_____

What is your primary source of water? ☐**Well** ☐**County**

Do you pre-medicate for dental appointments? ☐**Yes** ☐**No** **If so, why:** _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment.

_____ **Date:** _____

SIGNATURE **MM DD YY**

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I authorize payment of dental benefits to the named provider for professional services rendered and the release of any clinical records and x-rays necessary to process dental claims.

FINANCIAL POLICY & CONSENT FOR SERVICES

Dental Insurance: We will submit insurance claims as a courtesy on your behalf and utilize your benefits towards treatment rendered. We make every attempt to determine your insurance plan benefits. However, any treatments rendered that is not covered by your insurance plan due to limitations and/or exclusions will be your financial responsibility.

Co-payments and Deductibles: All co-payments and deductibles are expected at the time of service and it is a breach-of-contract with your insurance provider for them to be waived.

Financial Arrangements: As a condition of your treatment, financial arrangements must be made in advance. Complete payment must be made upon the completion of services. We do not offer a "payment plan" that will extend beyond the number of visits needed for your treatment. However, in order to make your treatment affordable, we will help you to arrange outside financing, if needed, prior to the initiation of treatment.

Digital Images and Radiographs: Photographs and images taken during treatment may be shown to other patients and doctors for educational purposes only.

Cancellation Policy: Your appointment time has been reserved for you. We understand that emergencies arise. However, in non-emergency situations, we expect 48-hour notification for cancelled appointments. Any non-emergency cancellation less than 48 hours prior to the appointment will be subject to a $50.00 cancellation fee.

_____ **Date:** _____

SIGNATURE **MM DD YY**

ACKNOWLEDGEMENT OF HIPPA POLICY NOTICE

I have had the opportunity to review the Notice of Privacy Practices.

_____ **Date:** _____

SIGNATURE **MM DD YY**