SIVI E. JONES DDS PC
JACQUELINE GAYMES DMD

1375 Clinton Avenue,
Irvington NJ 07111
973-375-7757

Sex: Male Female Date _____

Name of patient: _____ Age_____ Birth Date_____
First Middle Last

Name of insured person responsible for this account _____ Birth Date _____

Address _____ Phone _____
Street Apt. # City State Zip

Social Security # _____ Cell #_____

Occupation _____ Marital Status: ___ Single ___Married ___Widowed ___Divorced

Dental Insurance Plan _____ Group Number _____ Employer_____

Employer Address _____ Work Number _____

Spouse Name _____ Social Security # _____ Birth Date_____

Spouse Employer _____ Insurance_____ Phone_____

If patient is a college student, Name of School _____Graduation Date_____

The insurance company requires written proof of enrollment send with dental claim.

Referred By _____

MEDICAL INFORMATION

Physician Name_____ Address_____ Phone _____

IS THERE A HISTORY OF ANY OF THE FOLLOWING?

Yes No		Yes No		Yes No	
_____	**Allergy to Penicillin**	_____	**Psychiatric Care**	_____	**Sinus Problem**
_____	**Allergy to Other drugs**	_____	**Emotional Problems**	_____	**Physical/Mental Handicap**
_____	**Other Allergies**	_____	**Diabetes**	_____	**Thyroid Disorders**
_____	**Any Heart Ailments**	_____	**Hepatitis**	_____	**Eye Disorders**
_____	**Excessive Bleeding**	_____	**Asthma**	_____	**Cancer or Leukemia**
_____	**Tonsillitis**	_____	**Kidney Problems**	_____	**Seizure Disorder**
_____	**Heart Murmur**	_____	**Anemia, Blood Problems**	_____	**T.B**
_____	**Rheumatic Fever**	_____	**Hemophilia**	_____	**Sickle Cell Anemia or Trait**
_____	**Are you Pregnant**	_____	**Hypertension**	_____	**HIV (AIDS), ARC**
_____	**Extreme Nervousness**	_____	**Ever Hospitalized**	_____	**Biophosphonates**

_____

_____

_____

Describe any current medical treatments, drugs taken ect., even thought not listed above_____

_____

_____

What is the purpose of your visit? _____

What are your long term goals with regard to dental health? _____

For and in consideration of services rendered and /or to be render, I, the undersigned, hereby assign to Sivi E. Jones DDS PC any and all Dental Benefits which I may have under any policy of insurance. This will serve as signature on file. I will also be responsible for any balance owing after application of payment by any dental benefit payment.

Signature_____

Date_____