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_____