SIVI E. JONES DDS PC
JACQUELINE GAYMES DMD

1375 Clinton Avenue, Irvington NJ 07111
www.JonesDentalAssociates.com

PATIENT INFORMATION

Date: _____

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

Sex: ⊙Male ○Female ○Other

Name of patient: _____ Birth Date_____
First ` Middle Last

Address _____ Cell _____
Street Apt. # City State Zip

Email Address_____

Social Security # _____ Marital Status: ○Single ○Married ○Widowed ○Divorced

Referred By _____

DENTAL INSURANCE INFORMATION

Insurance Name _____ Group Number _____

Subscriber Name _____ Subscriber Social Security # _____ Subscriber Birth Date_____

Subscriber Employer _____

If patient is a college student, Name of School _____ Graduation Date_____

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

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	○	○	Bisphosphonate

Describe any current medical treatments, drugs taken etc., even though not listed above:

_____

What is the purpose of your visit? _____

I consent to dental treatment Yes____ No____ (initial)

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_____