Four Seasons Family Dentistry
Williamsburg Commons, 6A Auer Court, East Brunswick, NJ 08816
(732) 257-4062

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____(Cell):_____

Email Address:_____

May we confirm appointments by: Email ☐ Yes ☐ No Phone ☐ Yes ☐ No Text message ☐ Yes ☐ No

Address:_____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit:_____

Have your ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you 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:_____
- Please list any medications or herbal/natural supplements you are now taking_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

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 doctors at the next appointment without fail.

_____Date:_____
Signature of patient, parent or guardian

Medical History Reviewed By:_____ Date_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Facebook Ad ☐ Google/Bing Search ☐ Mail Advertisement ☐ Other_____

Name of person or office referring you to our practice:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call:_____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation:_____

Address: _____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address:_____

Street City State Zip Code

Insured's Employer Name:_____

Address:_____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address:_____

_____

Secondary

Name of Insured: _____Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address:_____

Street City State Zip Code

Insured's Employer Name:_____

Address:_____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address:_____

_____

Insurance Claim Authorizations

Your signatures on the following authorizations will be kept on file and enable computerized/electronic processing of your dental insurance claims. If you do not authorize payment to Four Seasons Family Dentistry, LLC, payment for treatment is due in full at the time treatment is provided.

I authorize the release of any information necessary for the processing of insurance claims. _____ Signed(Patient or Responsible Party) Date	I authorize the payment of benefits provided by my group dental plan directly to Four Seasons Family Dentistry, LLC. _____ Signed(Patient or Responsible Party) Date