NEW PATIENT INFORMATION FORM

NAME (Last, First, Middle):_____TITLE:_____

ADDRESS:_____

PREFERRED NAME:_____ SS NO: - - DOB: / /

HOME PHONE:_____ MARITAL: S/M/D/W REF. DOCTOR:_____

WORK PHONE:_____ SEX: M/F REF. PATIENT:_____

CELL PHONE:_____ EMAIL: _____

MEDICAL ALERTS:_____

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME:_____RELATION TO PATIENT: _____

ADDRESS:_____

SS NO: - - EMPLOYER:_____

DOB: / / ADDRESS:_____

PLAN NAME:_____ GROUP NO:_____ IND YRLY DEDUCT:_____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME:_____ RELATION TO PATIENT:_____

ADDRESS:_____

SS NO: - - EMPLOYER:_____

DOB: / / ADDRESS:_____

PLAN NAME:_____ GROUP NO:_____ IND YRLY DEDUCT:_____

INSURANCE CO: _____ FAM YRLY DEDUCT:_____

ADDRESS:_____ GROUP NO:_____

RESPONSIBLE PARTY

NAME AND ADDRESS:_____

SIGNATURE:_____

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

Height:

For Office Use Only
BP Heart Rate:

Weight:

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Anxiety
☐ ☐	Arthritis
☐ ☐	Artificial Heart Valve
☐ ☐	Artificial Joint/Bone Replacements
☐ ☐	Asthma
☐ ☐	Blood Transfusion
☐ ☐	Cancer
☐ ☐	Chemotherapy
☐ ☐	Cholesterol
☐ ☐	Colitis
☐ ☐	Congenital Heart Defect
☐ ☐	Cosmetic Surgery
☐ ☐	Depression
☐ ☐	Diabetes
☐ ☐	Drug Or Alcohol Abuse
☐ ☐	Emphysema
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Fever Blisters

Y N	Conditions
☐ ☐	Frequent Headaches
☐ ☐	Glaucoma
☐ ☐	HIV+ AIDS
☐ ☐	Hay Fever
☐ ☐	Heart Attack/Surgery
☐ ☐	Heart Murmur
☐ ☐	Hemophilia
☐ ☐	Hepatitis A/B/C
☐ ☐	High Blood Pressure
☐ ☐	Kidney Problems
☐ ☐	Liver Disease/Jaundice
☐ ☐	Low Blood Pressure
☐ ☐	Mitral Valve Prolapse
☐ ☐	Pace Maker
☐ ☐	Pneumocystitis
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Shingles
☐ ☐	Sickle Cell Disease
☐ ☐	Sinus Problems

Y N	Conditions
☐ ☐	Stroke
☐ ☐	Taken Fen-Phen
☐ ☐	Thyroid Problems
☐ ☐	Tuberculosis
☐ ☐	Ulcers
☐ ☐	

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Dr. Joseph G. Bonkowski Jr., DDS, MAGD
37 Meadow Street
Westfield, MA 01085-3241

NOTICE OF PRIVACY PRACTICES

*****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____ _____
Signature **Date**

For Office Use Only

We attempted to obtain written acknowledgement of reciept of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communication barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining the acknowledgement**
- ☐ **Other (Please Specify)**

_____
_____

This form is educational only, does not constitute legal advice, and covers only federal, not state, and law (August 14, 2002).