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:_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

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).