

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

Medications:

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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...

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Notes:

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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 receipt 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).