Kenneth A. Alongi, D.M.D., P.C.

General Dentistry and Orthodontics

PATIENT REGISTRATION

NAME______________________________ (LAST / FIRST / MIDDLE / (NAME PREFERRED)) DATE OF BIRTH__________ PRESENT AGE ______

❒ SINGLE
❒ MARRIED
❒ DIVORCED
❒ WIDOWED
❒ CHILD

ADDRESS ______________________ CITY______________ STATE________ ZIP________

HOME PHONE ______________ SS#______________ ❒ MALE ❒ FEMALE

WORK PHONE ______________ EMPLOYER ______________ OCCUPATION ______________

SPOUSE ______________ EMPLOYER ______________ WK # __________ S.S.# __________

NEAREST RELATIVE ______________ PHONE #______________ ADDRESS ______________

PERSON RESPONSIBLE FOR ACCOUNT

NAME______________ RELATIONSHIP__________

ADDRESS______________________

SOC.SEC. NO. ______________ OCCUPATION __________

EMPLOYER______________________

ADDRESS______________________

INSURANCE INFORMATION / DENTAL

NAME OF EMPLOYEE CARRYING INSURANCE /RELATION TO PATIENT __________

SOCIAL SECURITY NO. OF EMPLOYEE ______________

DATE OF BIRTH OF EMPLOYEE ______________

NAME OF EMPLOYER______________

NAME OF INSURANCE COMPANY______________

POLICY, ID OR CONTRACT # ______________ GROUP #__________

COMPLETE ONLY IF THERE IS A SECOND DENTAL INSURANCE POLICY

NAME OF EMPLOYEE CARRYING INSURANCE /RELATION TO PATIENT __________

SOCIAL SECURITY NO. OF EMPLOYEE ______________

DATE OF BIRTH OF EMPLOYEE ______________

NAME OF EMPLOYER______________

NAME OF INSURANCE COMPANY______________

POLICY, ID OR CONTRACT # ______________ GROUP #__________

I UNDERSTAND THAT ALL FEES FOR SERVICE ARE DUE AND PAYABLE AT THE TIME OF SERVICE. I AUTHORIZE INSURANCE BENEFITS TO BE PAID DIRECTLY TO KENNETH A. ALONGI, D.M.D. I FURTHER AUTHORIZE THE RELEASE OF INFORMATION NEEDED TO COMPLETE SETTLEMENT OF INURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE. I ALSO AGREE TO PAY COST OF ANY COLLECTIONS INCLUDING ATTORNEY FEES AND CREDIT BUREAU FEES.

____
PATIENT / PARENT

REFERRED BY______________________

FAMILY PHYSICIAN ______________________

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PAST MEDICAL HISTORY

NO	YES	
☐	☐	CARE OF A PHYSICIAN (WHO,WHY) __________
☐	☐	ALLERGIES? (DRUGS, OTHER __________
☐	☐	PRESENT MEDICATIONS (KINDS AND DOSAGE)__________
☐	☐	HEART MURMUR (KIND) __________
☐	☐	HEPATITIS, TUBERCULOSIS (KIND)__________
☐	☐	PROBLEMS WITH ANESTHETICS?__________
☐	☐	DIABETES (MEDICATION)__________
☐	☐	BLEEDING DISORDERS? (TYPE)__________
☐	☐	EPILEPSY? __________
☐	☐	ASTHMA (ANY BREATHING PROBLEM) __________
☐	☐	BLOOD TRANSFUSIONS? (WHEN, WHY?)__________
☐	☐	JOINT REPLACEMENT / OPERATIONS? __________
☐	☐	HEART ATTACK (WHEN) __________
☐	☐	POSITIVE TEST FOR HIV (AIDS)?__________
☐	☐	PREGNANT? __________
☐	☐	OTHER__________

PATIENT'S NAME ______________________ DATE ______________