Patient Information

Dr. Domenic Monaco, DMD, PA

Patient Name: (First) _____ (Last) _____

How would you like to be addressed? (Preferred Name): _____

Age: _____ Date of Birth: _____ Male: _____ Female: _____

Single: _____ Married: ____ Widowed: ____ Separated: ____ Other: ____ Minor: ____

Street Address: _____ City: _____ St.: _____ Zip: _____

Home Phone: _____ Alternate Phone (cell): _____

Business/Work Phone: _____

Social Security# _____ Driver's License# _____

Email Address: _____

Occupation: _____

Employer: _____

Dental Insurance: _____

Group# _____ Address: _____

Referred By: _____

Purpose of Initial Visit: _____

Previous Family Dentist: _____ City: _____

How Long: _____ Last Cleaning: _____

Family Physician: _____ City: _____

Physician's Phone # _____

How Long: _____ Last Physical Exam: _____

Spouse's Name (Parent or Guardian if minor): _____

Date of Birth: _____ Occupation: _____

Employer: _____ Employer Phone# _____

Social Security# _____ Dental Insurance: _____

Group# _____

DATE _____ **PATIENT/LEGAL GUARDIAN** _____

SIGNATURE: _____

Patient Health History

Dr. Domenic Monaco, DMD, PA

Oral History (Please check Yes or No)

Present Dental Complaint? _____

Do you have an unpleasant taste or odor in your mouth?	□ Yes	□ No
Are your teeth sensitive?	□ Yes	□ No
Do your gums bleed?	□ Yes	□ No
If so, when? _____		
Do you floss? (Please circle one)	Daily	Sometimes Never
Are your gums sore or swollen?	□ Yes	□ No
Are you unhappy with the appearance of your teeth?	□ Yes	□ No
Are you unhappy with the color of your teeth?	□ Yes	□ No
Does your jaw click or pop?	□ Yes	□ No
Do you clench or grind your teeth?	□ Yes	□ No
Have you ever had orthodontic treatment (braces)?	□ Yes	□ No
Have you had **periodontal** (gum) treatment previously?	□ Yes	□ No
If yes, by whom? _____		

Medical History

Height _____ Weight _____

How is your general health? GOOD FAIR POOR

Physician's Name & Phone Number: _____

(Please check Yes or No)

Are you now being treated or have you been treated within the last year by a physician? □ Yes □ No

Are you allergic, or have you reacted adversely, to any of the following?

Local anesthetics ("Novocaine")	□ Yes	□ No
Penicillin or other antibiotics	□ Yes	□ No
Sulfa Drugs	□ Yes	□ No
Barbiturates, sedatives, sleeping pills	□ Yes	□ No
Aspirin, Acetaminophen or Ibuprofen	□ Yes	□ No
Codeine, Demerol or other narcotics	□ Yes	□ No
Iodine	□ Yes	□ No
Reaction to metals	□ Yes	□ No
Latex or Rubber	□ Yes	□ No

Other _____

During the past 12 months, have you taken any of the following?

Antibiotics of Sulfa Drugs	□ Yes	□ No
Anticoagulants (Coumadin or Plavix)	□ Yes	□ No
High Blood Pressure medicine	□ Yes	□ No
Tranquilizers	□ Yes	□ No
Insulin, Orinase or similar drug	□ Yes	□ No
Aspirin	□ Yes	□ No
Digitalis or drug for heart trouble	□ Yes	□ No
Nitroglycerin	□ Yes	□ No
Cortisone (steroids)	□ Yes	□ No
Natural remedies	□ Yes	□ No
Nonprescription drug/supplements	□ Yes	□ No

Other: _____

Have you ever taken Biophosphates/Fosomax/Boniva? ..... □ Yes □ No

Please list all medications, drugs or pills you are taking (including aspirins, vitamins & herbs) and the reason?

_____

_____

_____

Do you have or have you had any of the following? Please check all that apply

Heart Problems □ Yes □ No
- Chest Pain □ Yes □ No
- Shortness of Breath □ Yes □ No
- High Blood Pressure □ Yes □ No
- Low Blood Pressure □ Yes □ No
- Heart Murmur □ Yes □ No
- Heart Valve Problem □ Yes □ No
- Taking Heart Medication □ Yes □ No
- Rheumatic Fever □ Yes □ No
- Pacemaker □ Yes □ No
- Artificial Heart Valve □ Yes □ No
- Defibrillator □ Yes □ No
- Heart Stents □ Yes □ No

Blood Problems □ Yes □ No
- Abnormal Bleeding □ Yes □ No
- Blood Disease (anemia) □ Yes □ No

Allergy Problems □ Yes □ No
- Hay Fever □ Yes □ No
- Sinus Problems □ Yes □ No
- Skin Rashes □ Yes □ No
- Asthma □ Yes □ No

Intestinal Problems □ Yes □ No
- Ulcers □ Yes □ No
- Weight gain or Loss □ Yes □ No
- Special Diet □ Yes □ No
- Kidney or Bladder Problems □ Yes □ No

Bone or Joint Problems □ Yes □ No
- Arthritis □ Yes □ No

Back or Neck Pain □ Yes □ No

Joint Replacement □ Yes □ No
(e.g., hip, pins or implants)

Fainting Spells, Seizures or Epilepsy □ Yes □ No

Neurological disease □ Yes □ No

Stroke □ Yes □ No

Headaches or Migraines □ Yes □ No

Thyroid Problems □ Yes □ No

Persistent Cough or Swollen Glands □ Yes □ No

Cancer/Tumor □ Yes □ No

Diabetes □ Yes □ No
- Frequent Urination □ Yes □ No
- Dry Mouth/Frequently Thirsty □ Yes □ No
- Family History of Diabetes □ Yes □ No

Tuberculosis or other respiratory disease □ Yes □ No

Do you drink alcohol? □ Yes □ No
If so, how much?
_____

Do you smoke? □ Yes □ No
If so, how much?
_____

History of alcohol or drug abuse? □ Yes □ No

Hepatitis, Jaundice or liver trouble □ Yes □ No

Herpes or other STDs □ Yes □ No

HIV/AIDS □ Yes □ No

Glaucoma □ Yes □ No

History of head injury? □ Yes □ No

Women:

Are you taking contraceptives or other hormones? □ Yes □ No

Are you pregnant? □ Yes □ No
If so, expected delivery date: _____

Are you nursing? □ Yes □ No

Have you reached menopause? □ Yes □ No
If so, do you have any symptoms? Please explain: _____
_____
_____

Do you have any disease, condition or problem not listed previously that you feel we should know about?
If so, please describe: _____
_____
_____

Would you like to speak to the doctor privately about any problem? □ Yes □ No

DATE: _____ PATIENT/LEGAL GUARDIAN (please print): _____

SIGNATURE: _____

WELCOME TO OUR PRACTICE

Dr. Domenic Monaco, DMD, PA

Please take the time to acquaint yourself with our office procedures and your financial obligations stated below. Should you have any questions regarding this, please bring it to our attention.
Thank You!

Appointment Confirmation
Our office will generally call 24 hours prior to your appointment to confirm your visit. However, it is your responsibility to remember your appointment to avoid any cancellation fees.

Cancellation Policy
If you are unable to keep your appointment time, you must notify our office 24 hours in advance to avoid any cancellation fees. If a patient does not show up, arrives late or cancels their appointment without 24 hours notice, a fee of $40.00 per half hour of scheduled appointment time will be charged to the patient (this fee is subject to change without prior notice).

Emergencies
Emergency time is available during our regular scheduled office hours, and the doctor can be reached on weekends for your emergency needs. If a patient is unable to meet the appointment time they are offered, then they will be given the next available appointment time.

Copy of Records
We will gladly provide you with a copy of your dental records, and or X-rays. Please note that the state requires us to keep the original records on file. Therefore, to cover our costs in duplicating documents, there is a nominal fee of $25.00 (cash only) per chart. Under the HIPAA Privacy Act, the patient must be present and sign paperwork to release such records. Any unpaid balance for services must be paid prior to the release of such records.

Insured Patients
We will gladly submit your dental claim for you. We can only submit the same claim a maximum of two times. If an insurance company has not paid a claim after a 45 day period, the entire balance is then the patient's responsibility. Adjustments will be made after the patient has settled the claim with their insurance company. **It is the patient's responsibility to know their dental coverage.** Your estimated portion of payment will be due the day treatment is rendered. A bill will be sent if there is a balance after insurance payments and or adjustments have been made. It is always the patient's responsibility to clear any balance not paid by the insurance company. **PLEASE NOTE:** In the event of benefit denial, it is not the responsibility of our office to appeal the claim. However, you have the right to personally appeal the rejected claim. **Pre-Determinations:** We will gladly submit a pre-determination to your insurance company on your behalf. Pre-Determinations take approximately 2-4 weeks for your insurance company to process. **PLEASE NOTE:** Pre-Determinations DO NOT guarantee coverage and payment. Your insurance company determines benefits once they receive a claim. It is the patient's responsibility to clear any balance not paid by the insurance company.

Un-Insured Patients
Our office offers **CareCredit** financial plans to any and all patients who qualify.
Patients without dental insurance are required to make payment in full at the end of their visit. Any financial concerns should be discussed prior to your appointment.

Past Due Accounts
A late fee will be assessed to all unpaid balances after the due date on the statement. Statements that have carried over the 30 day billing cycle will be subject to collection agency review. Any costs that arise from being in a collection account or legal review will be the patient's responsibility.

I have read and understand the Practice Policies

Print Name _____ **Date** _____

Signature _____

Dr. Domenic Monaco, DMD, PA
346 South Avenue, Suite 7
Fanwood, NJ 07023
908-889-2020

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options, please check your choice:

_____ Payment by Cash

_____ Payment by Check

_____ Payment by Credit Card

_____ Any Amount, not covered by insurance, Billed in FULL to your VISA, MasterCard or Discover

____ CareCredit®

Please sign below and return this form to our administrative staff before any treatment.

We accept VISA, MasterCard and Discover card payments.

If none of the payment options above apply to you, please see our administrative staff. Thank You

_____
Print Name

_____
Signature

_____
Date