CHILD'S REGISTRATION AND HISTORY

Date

Child's name | Nickname | Age | Birth date

Residence address | City | State | Zip

School | Address | Grade

Father's name | Mother's name

Father employed by | How long | Home phone | Bus. phone

Mother employed by | How long | Home phone | Bus. phone

Person financially responsible (if other than parent) | Relationship to child

Address | City | State | Zip | Phone

Father's Social Security number | Driver license no. | State

Mother's Social Security number | Driver license no. | State

Father's birth date | Mother's birth date

Credit card name | No. | Expiration date

When dental insurance coverage name of carrier

Secondary insurance coverage, if any

Whom may we thank for referring you

What is child's favorite: sport | toy | hobby | person | fictional character

DENTAL HISTORY

Date of last visit to a dentist _____

For what service _____

	Yes	No
Has child complained about dental problems	☐	☐
Any unhappy dental experiences	☐	☐
Any injuries to mouth - teeth - head	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.	☐	☐
Any unusual speech habits	☐	☐
Any lost teeth	☐	☐
Have missing teeth been replaced	☐	☐
Orthodontic appliances worn now or ever been	☐	☐

	Yes	No
Does your child brush teeth daily	☐	☐
Do you assist child with tooth brushing	☐	☐
How often		
Is dental floss used	☐	☐
How often		
Are disclosing tablets used	☐	☐
Is fluoride taken in any form	☐	☐
Do you desire complete dental service for the child	☐	☐

Child's attitude to dentistry _____

Summary (for doctor's use) _____

HEALTH HISTORY

Child's physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	Yes	No
Is child under care of physician now _____	☐	☐
Is child receiving any medication or drugs _____	☐	☐
Is there any excessive bleeding when cut _____	☐	☐
Has child ever been hospitalized _____	☐	☐
Has child ever had surgery _____	☐	☐
Is there any allergy to penicillin or other drugs _____	☐	☐
Are there other allergies: food - pollen - animals - dust - other	☐	☐

	Yes	No
Does child have good physical coordination _____	☐	☐
Are there any emotional problems _____	☐	☐

Summary (for doctor's use) _____

Has child any history of or difficulty with any of the following:

__ Anemia
__ Asthma
__ Bladder
__ Cerebral Palsy
__ Chicken pox
__ Chronic sinus
__ Convulsions
__ Diabetes
__ Epilepsy
__ Fainting
__ Hearing
__ Heart
__ Kidney
__ Liver
__ Malignancies
__ Mastoid
__ Measles
__ Mononucleosis
__ Mumps
__ Rheumatic fever
__ Thyroid
__ Tuberculosis
__ Veneral disease
__ Other

Summary: (for doctor's use)

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

_____

_____

_____

_____

	Yes	No
May we request release of your child's medical records for our reference _____	☐	☐

This information was discussed with and given by _____

Relation to child _____

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