PATIENT HEALTH HISTORY FORM

Date: _____

Name: _____
Last First MI PREFERRED NAME

Address: _____ City_____ Zip_____

Gender: M / F Birthdate:_____/_____/_____ Marital Status: _____

Social Security #:_____-_____-_____ Driver's License #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Occupation: _____ Employer:_____

Who may we thank for referring you? _____

Spouse Name: _____ Spouse's Employer: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PREFERRED PHARMACY

Pharmacy Name: _____ Pharmacy Phone: _____

Crossroads:_____

DENTAL HISTORY

Reason for Today's Visit _____

Are you currently experiencing dental pain or discomfort? Y / N If yes, where? _____

Do your gums bleed when you brush or floss? Y / N

Are your teeth sensitive to hot, cold, sweets or pressure? Y / N

Does food or floss catch between your teeth? Y / N If YES, where? _____

Do you snore or suffer from sleep apnea? Y / N

Do you suffer from Dry Mouth? Y / N

Do you grind your teeth or have jaw/TMJ pain? Y / N

What if anything, would you change about your smile?

_____

***** IF YOU DO NOT HAVE INSURANCE YOU MAY SKIP THIS PAGE *****

DENTAL INSURANCE

PRIMARY DENTAL

Insurance Name: _____ Insurance Phone #: _____

Subscriber: _____ Relationship: _____

Insured's Employer: _____ Insured's SS #: _____-_____-_____

Insurance ID#: _____ Subscriber Date of Birth: _____/_____/_____

SECONDARY DENTAL

Insurance Name: _____ Insurance Phone # : _____

Subscriber: _____ Relationship: _____

Insured's Employer: _____ Insured's SS # : _____-_____-_____

Insurance ID#: _____ Subscriber Date of Birth: _____/_____/_____

MEDICAL INSURANCE

DENTAL INSURANCE PLANS ARE CHANGING, THERE ARE SOME PROCEDURES THAT REQUIRE US TO BILL YOUR MEDICAL INSURANCE OR MAY BE BILLABLE TO YOUR MEDICAL INSURANCE. PLEASE PROVIDE THIS INFORMATION AS NOT TO DELAY INSURANCE PROCESSING. THANK YOU!

PRIMARY MEDICAL

Insurance Name: _____ Insurance Phone #: _____

Subscriber: _____ Relationship: _____

Insured's Employer: _____ Insured's SS #: _____-_____-_____

Insurance ID#: _____ Subscriber Date of Birth: _____/_____/_____

SECONDARY MEDICAL

Insurance Name: _____ Insurance Phone # : _____

Subscriber: _____ Relationship: _____

Insured's Employer: _____ Insured's SS # : _____-_____-_____

Insurance ID#: _____ Subscriber Date of Birth: _____/_____/_____

MEDICAL HISTORY

Do you require antibiotics (PRE MED) before dental treatment? Y / N

If yes, please state why _____

Are you under the care of a physician? _____

Physician's Name: _____ Phone: _____

Address: _____

Do you take Blood Thinner or Blood Pressure Medication? Y / N

Please list all current prescription or herbal medications you are taking: _____

_____

_____

Are you Allergic to any of the following:

Aspirin: Y / N	Barbiturates: Y / N	Codeine: Y / N
Dental Anesthetics: Y / N	Erythromycin: Y / N	Jewelry/Metals: Y / N
Latex: Y / N	Penicillin: Y / N	Sedatives: Y / N
Sulfa Drugs: Y / N	Tetracycline: Y / N	Iodine: Y / N

Additional drugs/medications that cause allergic reactions:

_____

_____

Have you had a joint (hip, knee, elbow, finger) replacement? _____

If yes, Date: _____ Surgeon's Name & Phone: _____

Have you or are you scheduled to begin taking either of the medications Alendronate (FOSAMAX) or Risedronate (Actonel) for Osteoporosis or Paget's Disease? _____

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates AREDIA or ZOMETA for bone pain, hyperkalemia or skeletal complications from Paget's disease, multiple myeloma or metastatic cancer? _____ Date Treatment Started: _____

Do you use controlled substances (drugs)? _____

Do you use tobacco (smoking, snuff, chew, bides)? Y / N If yes, what and frequency: _____

If so how interested are you in stopping? VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? Y / N Consumption in last 24 hrs? _____

How much do you typically drink in a week? _____

DO YOU HAVE OR EVER HAD:

Yes	No	Oral Surgery	Yes	No	Heart Attack
Yes	No	Periodontal Surgery	Yes	No	High Blood Pressure
Yes	No	Complication from Dental Surgery	Yes	No	Low Blood Pressure
Yes	No	Abnormal Bleeding	Yes	No	Mitral Valve Prolapse
Yes	No	Eating Disorder	Yes	No	Heart Surgery (Date_____)
Yes	No	Acid Reflux	Yes	No	Heart Murmur
Yes	No	Nervous Problems	Yes	No	Smoke
Yes	No	Epilepsy	Yes	No	Implants (Type_____)
Yes	No	Fainting Spells	Yes	No	Stroke
Yes	No	Freq. Headaches/Migraines	Yes	No	Circulatory Problems
Yes	No	Arthritis	Yes	No	Kidney Disorder
Yes	No	Prosthetic Joints	Yes	No	Thyroid Problem
Yes	No	Artificial Heart Valves	Yes	No	Liver Disease
Yes	No	Radiation/Chemo	Yes	No	Tuberculosis
Yes	No	Asthma	Yes	No	Convulsions or Seizures
Yes	No	Rheumatic Fever	Yes	No	Ulcers
Yes	No	Scarlet Fever	Yes	No	Diabetes
Yes	No	Blood Transfusions	Yes	No	Blood Disease
Yes	No	Hemophilia	Yes	No	AIDS/HIV
Yes	No	Sinus Problems	Yes	No	Hepatitis (date_____)
Yes	No	Cancer	Yes	No	Venereal Disease
Yes	No	Pacemaker	Yes	No	Drug Abuse
Yes	No	Chest Pain	Yes	No	Alcohol Addiction

Please explain any hospitalizations, surgeries or serious medical conditions:

_____

_____

_____

WOMEN ONLY

YES NO Currently Taking Birth Control – If so, Medication Name: _____

YES NO Currently Pregnant – If so, how many weeks along: _____ Weeks

YES NO Currently Nursing

OBGYN Name: _____ Phone: _____

If dental treatment is needed during pregnancy or if you are nursing, prior authorization from doctor may be needed.

Patient Signature: _____ **Date :** _____

Gregory J. Mansour, DDS, PC
1800 W. Auburn Road, Rochester Hills, MI 48309 ● (248) 852-3130 ● www.MansourDDS.com

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require that you read, agree to and sign prior to any treatment.

PAYMENTS/CO-PAYMENTS

- All patients must complete our "Patient Information Form" before seeing the doctor. This form will be required to update every 5 years or sooner if there are any insurance or patient health changes.
- We accept cash, checks and Visa/MasterCard, American Express and Discover.
- Patients with Insurance – Copayment or estimated copayment is due at the time of service.
- Patients without Insurance – Payment for services is due at the time of service.
- Auto accident, worker's comp or accident claims – Patient must pay in full at time of service and seek reimbursement for the claim. Sorry for any inconvenience. (Excludes OneCallCare Claims)

REGARDING INSURANCE

We may accept assignment of benefits with your insurance; however, we require the correct co-payment to be paid at the time of service. For all new patients and patients of record the balance is your responsibility whether your insurance company pays or not. Any outstanding balance will be subject to late fees and/or finance charges. We cannot bill your insurance company unless you bring in all correct insurance information. Your insurance policy is a contract between you and your insurance company, we are not a party to that contract. However, we will still continue to assist you in acquiring payment from your insurance carrier.

MINORS

The adult accompanying a minor and the parent/guardian is responsible for full payment. For separated or divorced families, the parent/guardian that registers the patient will be responsible for payments/copayments incurred. Our office does not get involved in personal or custody matters between parents/guardians. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card or payment by cash or check at time of service has been verified.

UCR (Usual and Customary Rate)

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. We strive to give you the most accurate estimate when it comes to your insurance coverage. You are responsible for paying the bill in full regardless of the insurance company's determination of usual and customary rates.

MISSED APPOINTMENTS

In order to keep costs down, keeping your scheduled appointment is important. We offer multiple options for appointment reminders (cards, e-mail, text, and phone call). Unless cancelled at least 48 hours in advance, our policy is to charge $50.00 for any short notice cancel or missed appointment. Please help us to serve you better by keeping your scheduled appointments.

PAST DUE ACCOUNTS

If you are unable to pay your balance please make arrangements with our billing department as soon as possible. Any accounts over 90 days will incur a $35.00 late fee and may be reported to credit bureaus, unless financial arrangements have been made. If you have insurance claims that are outstanding over 60 days, we recommend following up with your insurance company.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the above Financial Policy.

_____ _____

Patient or Responsible Party Date

Gregory J. Mansour, DDS, PC
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ACKNOWLEGEMENT
RECEIPT OF NOTICE OF PRIVACY PRACTICES
FOR
Gregory J. Mansour, D.D.S., P.C.

You may refuse to sign this acknowledgement
By signing below, I acknowledge that I have received the Notice of Privacy Practices from this practice.

_____

Print Patient Name

_____ _____

Patient or Guardian Signature Date

I authorize Gregory J. Mansour, DDS, PC to discuss treatment and financial matters with:

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____

****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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):_____

_____