PATIENT HEALTH HISTORY FORM

Date: _____

Name: _____
Last First MI

Address: _____ City_____ Zip_____

Gender: 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: _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name: _____ Social Security #:_____-_____-_____

Address: _____ Relationship: _____

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

EMERGENCY CONTACT

Name: _____ Relationship: _____

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

DENTAL INSURANCE

PRIMARY
Insurance Name: _____ Insurance Phone # : _____

Subscriber: _____ Relationship: _____

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

Insured's Driver License #: _____

SECONDARY
Insurance Name: _____ Insurance Phone # : _____

Subscriber: _____ Relationship: _____

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

Insured's Driver License #: _____

DENTAL HISTORY

Reason for Today's Visit _____

Are you currently experiencing dental pain or discomfort? 'es, where? _____

Do your gums bleed when you brush or floss?

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

Does food or floss catch between your teeth? S, where? _____

Do you snore or suffer from sleep apnea?

Do you suffer from Dry Mouth?

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

What if anything, would you change about your smile?

_____

MEDICAL HISTORY

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

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?

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

_____

_____

Are you Allergic to any of the following:

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

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)? If yes, what and frequency: _____

If so how interested are you in stopping?

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

How much do you typically drink in a week? _____

DO YOU HAVE OR EVER HAD:

Abnormal Bleeding
Eating Disorder
Nervous Problems
Acid Reflux
Epilepsy
Oral Surgery
AIDS/HIV
Fainting Spells
Pacemaker
Alcohol Addiction
Freq. Headaches/Migraines
Periodontal Surgery
Arthritis
Heart Attack
Prosthetic Joints
Artificial Heart Valves
Heart Murmur
Radiation/Chemo
Asthma
Heart Surgery
Rheumatic Fever
Blood Disease
Hemophilia

Scarlet Fever
Blood Transfusions
Hepatitis (date_____)
Sinus Problems
Cancer
High Blood Pressure
Smoke
Chest Pain
Implants (Type_____)
Stroke
Circulatory Problems
Kidney Disorder
Thyroid Problem
Complication from Dental Surgery
Liver Disease
Tuberculosis
Convulsions or Seizures
Ulcers
Diabetes
Low Blood Pressure
Venereal Disease
Drug Abuse
Mitral Valve Prolapse

Please explain any hospitalizations, surgeries or serious medical conditions:

_____

_____

WOMEN ONLY:
Are you taking Birth Control Pills: Are You Pregnant? Week #_____ Are you Nursing?

Patient/Guardian 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.

All patients must complete our "Patient Information Form" before seeing the doctor.

For patients without insurance, Full payment is due at the time of service.

We accept cash, checks and Visa/MasterCard, American Express and Discover.

REGARDING INSURANCE

We may accept assignment of insurance; however we do 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 billing 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.

ADULT PATIENTS

Adult patients are responsible for full payment at time of service as written above.

MINORS

The adult accompanying a minor and the parents (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard 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. You are responsible for paying the bill in full regardless of the insurance company's determination of usual and customary rates.

MISSED APPOINTMENTS

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

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

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

_____ _____

Patient or Responsible Party Date

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

By signing below, I acknowledge that I have received the Notice of Privacy Practices from this practice.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

FOR CHILDREN WHO ARE OR WILL TURN 18 AND STILL ON PARENTS INSUANCE PLEASE SIGN BELOW

DO NOT SIGN THIS PORTION IF IT DOES NOT APPLY TO YOU

As a patient who is over (or may turn 18 during treatment), I give my permission for treatment and financial matters to be discussed with my parents at any time.

_____
Patient Signature