FAMILY Laser & Cosmetic DENTISTRY

PEDIATRIC PATIENT HEALTH HISTORY

Date: _____

Child's Name: _____ Date of Birth: _____
FIRST MI LAST

Address: _____
ADDRESS CITY STATE ZIP

Gender: ☐ Home Phone: _____

Mother's Name: _____ Cell Number: _____

Father's Name: _____ Cell Number: _____

Parent Email Address: _____

DENTAL INSURANCE

PRIMARY

Insurance Name: _____ Insurance Phone # : _____

Subscriber: _____ Relationship: _____

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

MEDICAL HISTORY

Is your child allergic to:

Penicillin ☐ Erythromycin ☐ Ceclor ☐ Sulfa ☐ Tree Nuts ☐ Latex ☐

Other: _____ _____

Is your child taking any medications: ☐

List each medication and dosage: _____

AIDS/HIV: ☐	Eating Disorder: ☐	Spectrum Disorder: ☐
Cerebral Palsy: ☐	Asthma: ☐	Heart Disorder/Surgery: ☐
Arthritis ☐	Epilepsy/Seizures ☐	Blood Disorder/Anemia: ☐
Diabetes ☐	Attention Deficit	Hepatitis: ☐
Artificial joints/prosthetics ☐	disorder/Hyperactivity: ☐	Cancer: ☐
Down Syndrome: ☐	Hearing Impaired: ☐	Kidney Disease: ☐
Asperger's Syndrome ☐	Autism: ☐	

Other: _____

_____ _____
Parent/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