PEDIATRIC PATIENT HEALTH HISTORY

Date: _____

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

Address: _____
ADDRESS CITY STATE ZIP

Gender: M / F 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 **Y/N** Erythromycin: **Y/N** Ceclor: **Y/N** Sulfa: **Y/N** Tree Nuts: **Y/N** Latex: **Y/N**

Other: _____ _____

Is your child taking any medications: **Y/N**

List each medication and dosage: _____

AIDS/HIV: **YES NO**
Cerebral Palsy: **YES NO**
Arthritis: **YES NO**
Diabetes: **YES NO**
Artificial joints/prosthetics: **YES NO**
Down Syndrome: **YES NO**
Asperger's Syndrome: **YES NO**

Eating Disorder: **YES NO**
Asthma: **YES NO**
Epilepsy/Seizures: **YES NO**
A.D.D./A.D.H.D.: **YES NO**
Hearing Impaired: **YES NO**
Autism: **YES NO**

Spectrum Disorder: **YES NO**
Heart Disorder/Surgery: **YES NO**
Blood Disorder/Anemia: **YES NO**
Hepatitis: **YES NO**
Cancer: **YES NO**
Kidney Disease: **YES NO**

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.

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

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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):_____