Manhattan Dental Associates
Patient Registration

Last Name ______________________ First ____________________ Date ____

Social Security# ____________________ Date of birth __________________

If married, spouse's name ____________ E-mail address ________________

Home Address ____ Apt# ______

City _________________________ State _________________ Zip ________

Home Phone ___________ Business Phone ___________ Cellular Phone __________

Employer _________________________ Business Address __________________

Insurance Company ___________________ Name of Union ____________________

Name and Social Security # of Insured Person ____________________________

Date of birth __________ Group# ______________ Policy # ___________________

In case of emergency who should we contact? Name _________________________

Address ___________________________ Phone _____________________________

Who referred you to this office? ____

Medical History

Have you ever had? Answer yes or no.

High blood pressure __ Thyroid disease _______ Liver disease _____

Rheumatic fever __ Venereal disease ______ Asthma ______

Hepatitis __ Epilepsy ____________ Diabetes. ______

Heart Disease _______ Heart murmur ________ Artificial Heart Valve _____

Heart Attack/Stroke ______ Cancer/Tumor ________ AIDSIHIV Positive ____

Orthopedic Pins ______ Kidney Disease _______ Other ______

Have you ever had a bad reaction to *penicillin, codeine, Novocain or any other medication?* _________ Are you allergic to *latex?* ________ Any other allergies? __

Are you presently taking any medications? ________________________________

Have you ever had prolonged bleeding from a cut or following extraction of a tooth? _

Have you ever been hospitalized? _______ For what reason? ____________________

Are you pregnant? _________________________ Do you smoke? _________________

Physician's name ________________ Phone ______________ Date oflast physical? __

Are you presently under physician's care? ____________________________

When was your last dental visit? ________ What did you have done at that visit? ______

Your reason for today' s visit? ____

All delinquent balances are subject to 1.5% monthly finance charge. Any collection expenses incurred are the responsibility of the patient. As a service to our patients, we will accept your Dental Insurance as full or partial payment for services rendered in our office. We ask that any difference between our fees and the amount paid by the insurance company be paid by you the patient. There is a $10 billing fee for copayments not paid on the date of service. Returned check will be subject to a $35 fee. Signature, ______________________________

I understand that I will be charged $50 for appointments cancelled or broken without 24 hours notice. Cancellations after office hours will be accounted towards the next business day.

Signature ___________________________________ Date ________

Manhattan Dental Associates LLP
Elliot L. Rifkin, D.M.D.
Ronald S. Kushner, D.M.D.
*2 West 45th Street * Suite 1008 * New York, New York 10036* 212-944-2836*

Dear patient:

In an effort to provide you with quality Dental Care and flexible payment arrangements we have expanded our payment policy.

Payment arrangements are requested at the time of you visit.

We now offer the following payment options:

_ Payment by cash

_ Payment by check

_ Payment by credit card

_ Automatic monthly billing to your *Visa or Mastercard*

_ Guarantee your insurance co-payments with *Visa or Mastercard*

Please make your choice, sign below and return to the receptionist before your visit.

Our office program is fully approved and accredited user ofthe *VisaiMastercard Health Care Incentive Program* which will enable you to use your *Visa/mastercard* to automatically cover amounts not paid by insurance. You may also choose a comfortable amount to be automatically billed to your *Visa or Mastercard* on a monthly basis.

Ifnone ofthe above options apply, lease see the receptionist.

Print your name here and sign below:

MANHATTAN DENTAL ASSOCIATES

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Manhattan Dental Associates we may use or disclose personal and health related information about you in the following ways:

Your protected health information, including you clinical records may be disclosed to another health provider if it is necessary to refer you for further diagnosis, assessment or treatment.

Your dental care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are responsible for the payment of services provided to you.

Your name, address, phone number and your dental care records may be used to contact you regarding appointment reminders, information about alternatives to your present care or other health related information that may be of interest to you.

You have a right to request restrictions on our use of protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

If you are not at home or at work to receive an appointment reminder or other related information, a message may be let on your answering machine, voice mail, or with a person in your household or workplace. You have the right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

If we provide health care services in an emergency.

If we are required by law to provide care to you and we are unable to obtain your consent attempting to do so.

If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any disclosure of your protected health information, other than as outlined above, will only be made upon written authorization. If you provide an authorization for release of information you have the right to revoke authorization at a later date. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide information and may no longer be protected by the federal privacy rules.

We normally provide information about your health at the time you receive dental care from us. We may also mail information to you regarding you health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

Weare required by state and federal law to maintain privacy of your patient file and the health protected heath information therein. We are also required to provide you with this notice of our privacy practices

with respect to your health information. We are further required by law to abide by the terms of his notice while it is in effect..

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your complaint to:

If you would like further information about our privacy policies and practices please contact:

Manhattan Dental Associates
2 West 45th Street Suite 1008
New York, NY 10036
212-944-2836

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary, your care will continue and this office or our staff in any manner whatsoever will not disadvantage you.

This notice is effective April 15, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

______________________	______________________	____________
Name (printed please)	Signature	Date

If you are a minor, or being represented by another party.

______________________	______________________	____________
Personal Representative Printed	Personal Representative Signature	Date

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Description of the authority to act on behalf of the patient..