Welcome to Manhattan Dental Studio, where delivering quality dental care for optimal health is our main objective. You can rest assured in knowing that Dr. Tomack, Dr. Behrens and Dr Soloway have your best interest in mind.

Patient Name_____
SS# _____ Date of Birth _____
Address_____ Apt # _____
City, State Zip _____ Email _____
Home Phone _____Cell Phone _____Work Phone_____
What is the best way to reach you? (Circle One) Home Cell Work Email
Emergency Contact & Phone _____

INSURANCE (If you have secondary insurance info please inform the front desk staff.)
Name of Policy Holder (If different than above) _____
Policy Holder Date of Birth _____ Policy Holder SS# _____
Employer _____
Name of Insurance _____ Ins Phone # _____
Insurance Address_____
Member ID #_____ Group #_____

Whom may we thank for your referral? _____

In consideration of the others who need care, if you are unable to keep an appointment we ask that you please give at least a 24 hours notice. There is a **$25.00 broken appointment fee** that applies should you cancel or reschedule within 24 hours of your appointment time, which we donate to St. Jude Hospital on your behalf. INITIAL HERE_____ DATE_____

AUTHORIZATION & CONSENT

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits or to another healthcare professional.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. **I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts.** By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, by my dental care payor. I attest to the accuracy of the information on this page. Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES (Please see attached Take Home Hand Out)
This notice says that we will not share your information with a third party without your consent.

I acknowledge that I have received and read a Notice of Privacy Practices in its entirety from Manhattan Dental Studio.
Signature_____Date_____

DENTAL HISTORY
Reason for today's visit _____
Date of last dental visit _____ Former Dentist_____
Date of last dental x-rays _____ Do You Use: Floss? Yes No Electric Tooth Brush? Yes No
Are you happy with the appearance of your teeth and your smile? Yes No If Not, what would you like to change?_____
Are you interested in having whiter teeth? Yes No
Have you ever had an allergic reaction to Novocain, local, or general anesthetics? Yes No
If Yes, please explain _____
Have you ever had trouble from previous dental care? Yes No If Yes, please explain
_____

(If additional space is needed, please list on the bottom of this form)

	YES	NO		YES	NO
Bleeding/Swollen Gums			Trouble Chewing		
Sensitive to Hot/Cold/Sweets			Pain in your jaw		
Clench/Grind Teeth			Blisters on lips or mouth		
Food collection between teeth			Bad Breath		
Growths or sore spots in your mouth			Dry mouth		

Any comments or anything else we should know about your dental health?
_____
_____
_____

Signature_____ Date_____

MEDICAL HISTORY

Are you currently under the care of a Physician? Yes No If so, for what?

_____

Physician's name _____ Date of last visit_____

Are you taking any medication?_____

(If additional space is needed please list on the bottom of this form)

Are you allergic to any medication, i.e. local anesthetic, Penicillin, Aspirin, Sulfa, Codeine? Yes No

_____

Do you smoke? Yes No How much?_____

Do you consume alcoholic beverages? Yes No If so, how many per week?_____

Have you had any serious illnesses, operations or blood transfusions? Yes No If yes, please describe _____

(Women) Are you pregnant? Yes No Due date _____ Nursing? Yes No

Taking birth control pills? Yes No

	YES	NO		YES	NO
Heart problems			Mitral valve Prolapse		
Heart Attack			Tuberculosis		
High/Low blood pressure			Fainting /Dizzy spells		
Rheumatic fever			Latex Allergy		
Diabetes			Chemical dependency		
Hepatitis, Liver Disease			Stroke		
Pacemaker			Any immune deficiency		
Artificial heart valves			Artificial joints		
Asthma			Anemia		
Thyroid problems			Kidney disease		
Bone Disease/Taking Fosamax			Bruise Easily		
Sexually Transmitted Disease			AIDS, HIV		
Abnormal Bleeding			HPV		
Blood disease, clotting disorders			Ulcer		
Epilepsy/Convulsion/Seizures			Shortness of Breath		
Eye Disease/Glaucoma			Cancer		

If you answered yes, to any of the questions above please explain.

Is there anything else about your health that we should know?

_____

_____

_____

_____

SIGNATURE_____Date _____

PRINT NAME _____ Date _____

INSURANCE AND FINANCING

We understand that insurance can be confusing. Please know that we are here to help in any way we can, but we do not control what the insurace company will cover or reimburse you. Your insurance plan is an agreement between you and the insurance company. We do not dictate how or what the insurance company will pay. We encourage you to become familiar with your policy's exclusions and deductibles. We will always help our patients maximize their benefits, including same day electronic form filing with the insurance company. **Patients are ultimately responsible for the full cost of treatment, whether or not we accept assignment of benefits.**

Our expectations of you as the owner of the insurance policy:

1. Payment of fees not covered by your insurance plan at the time the service is rendered
2. Researching your dental insurance plan to advise you of benefits available to you
3. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from you insurance carrier
4. Realize that dental insurance policies restrict payment for some services, use restricted fee schedules (called usual and customary rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment
5. Keeping our office informed of any changes in your insurance coverage
6. Taking responsibility for payment if the insurance company does not pay our office within 45 days - or for any unpaid balance - with a pre-arranged credit card authorization

I HAVE READ #1-6 (ABOVE). I ACCEPT THE TERMS.

Signature_____ Date _____

I hereby authorize benefits to be paid directly to Dr. Tomack and Dr. Behrens of Manhattan Dental Studio. I understand that I am responsible for any unpaid balance. I give permission to settle my balance with the credit card information below for any outstanding balance after 45 days.

Visa MasterCard American Express Discover CareCredit

Card Number_____ Exp. Date_____

Print Name_____ Date_____

Signature_____Date_____

MANHATTAN
DENTAL STUDIO

VELSCOPE- ORAL CANCER SCREENING

We know that oral cancer claims one life every hour in the US – more than the number of lives lost to skin cancer, cervical cancer or Hodgkin's disease, and it is of great concern to our doctors and hygienists.

Oral Cancer is one of the most curable diseases when caught early. This practice has incorporated the Velscope Oral Cancer Screening technology into the standard of care of the practice.

Velscope technology uses a wavelength of light which causes normal tissue to fluorescent green. Diseased tissue lacks this fluorescence. This allows us to see the diseased area before it is visible to the naked eye. It is a simple, painless and non-invasive technology that improves the Doctor's ability to visualize, mark, evaluate and monitor suspicious areas at their earliest stages, before they can progress to something far more serious, and potentially life-threatening.

Risk factors and Screening Recommendations:

• The incidence of oral cancer in young adults is increasing
• 50% of all newly diagnosed oral cancers are in individuals who do not have the historic risk factors of tobacco and alcohol usage.
• It is believed that the increase in oral cancers is due to HPV (human papilloma virus) as the majority of these tumors have the virus present in the tissue.
• The good news is that these cancers can be discovered and treated early with good results.
• The Oral Cancer Foundation now recommends an annual screening for anyone old enough to engage in sexual behaviors in order to catch the disease at its earliest possible stages.

The cost for this screening is $28.00; and we recommend that this be done once per year. We will be happy to submit to your insurance company on your behalf.

Please make a choice:

I _____ WOULD like this screening.
Patient Signature

I _____ DO NOT want this screening at this time.
Patient Signature

_____ _____
PRINT NAME DATE