Patient Name:
Birthdate:

Medications

Do you take any medications?	Yes	No	If so list all:
*Do you take blood thinners?	Yes	No	If so list all:
*Have you ever taken fosomax, boniva, actonel, or any bisphosphonates?	Yes	No	If so list all and when:
*Have you ever taken antibiotics prior to dental treatment	Yes	No	If so why:

Allergies

Have you had any allergies?	Yes	No	If so list all:

Women

*Are you pregnant?	Yes	No	If so what is your due date?
*Are you taking birth control?	Yes	No	If so what type?
Are you nursing?	Yes	No	

Advanced Directives

Do you have a healthcare proxy?	Yes	No	If so who?
O DNI (do not intubate) order	O DNR (do not resuscitate) order		
O Living will	O Copies in office on file (please bring in copies for your chart)		

Race, Ethnicity and Language

What is your race?	What is your ethnicity?	Primary language spoken? O Translation services needed

Sign and date where applicable

Patient Name:	Patient Signature:
Name of Representative:	Representative Signature:
Patient Guardian:	Guardian Signature:
Date:	

Practice Logo

Acknowledgement

Consent for Treatment, Patient Rights and Responsibilities and Notice of Privacy Practices

Patient Name:	Id:	DOB:	Gender:

CONSENT FOR TREATMENT

I hereby give my consent to Baker Victory Healthcare Center dental staff to examine and treat me, my child or the patient named above. I understand that as part of my health care, Baker Victory Healthcare Center originates and maintains medical records describing my:

- Health history
- Examination
- Diagnoses
- Financial information
- Plans for future care and treatment
- Symptoms
- Test results
- Treatment
- Demographic information

I understand that I may revoke this consent at any time, in writing, except for services I have already received.

I have been informed of the purpose of the treatment and the expected benefits and complications from known and unknown causes, associated discomforts and risk that may arise, as well as possible alternatives to the proposed treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

PATIENT RIGHTS AND RESPONSIBILITIES & NOTICE OF PRIVACY PRACTICES

I acknowledge that Baker Victory Healthcare Center has provided me with a written copy of:

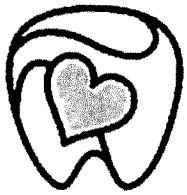
- Patients Rights and Responsibilities (PRR) - defines my rights and responsibilities as a patient that receives health care services from Baker Victory Healthcare Center.
- Notice of Privacy Practices (NPP) - provides information about how my health information may be disclosed.

I acknowledge that I have been given the opportunity to read both the PRR and NPP and ask questions.

I understand and consent to the use and disclosure of my health information to the health care providers and professionals for the provision of my care.

ASSIGNMENT OF BENEFITS

I understand that in order to have Baker Victory Healthcare Center bill my insurance (Medicare, Medicaid, medical program, insurance company or other payor) I am authorizing Baker Victory Healthcare Center to release any information necessary. I understand I have the right to request restrictions as to how my health information may be used and disclosed to carry out treatment, payment, or health care operations.



DENTAL CENTER

AT OLV HUMAN SERVICES

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BAKER VICTORY HEALTHCARE CENTER – DENTAL CENTER

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Baker Victory Healthcare Center as your dental care provider. The dental services you seek may require a financial responsibility on your part. Such a responsibility would obligate you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding such financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing. By signing below and/or by receiving dental services from Baker Victory Healthcare Center Dental Center ("Dental Center"), you agree to all of the following:

1. You acknowledge and agree to the established policies and procedures of the Dental Center, including but not limited to this PATIENT FINANCIAL RESPONSBILITY STATEMENT, in effect from time-to-time ("Policies"). You may request a copy of the current Policies from the Dental Center Office Staff. These Policies may be changed from time-to-time by the Dental Center, without notice. If there is any conflict between another policy or procedure of the Dental Center and this PATIENT FINANCIAL RESPONSIBILITY STATEMENT, this Statement shall control.

2. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or our Policies, which may not otherwise be covered by supplemental insurance.

3. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply:

(i) your dental/insurance plan requires prior authorization or referral before receiving services and you have not obtained such an authorization or referral;
(ii) you receive services in excess of such authorization or referral;
(iii) your dental/insurance plan determines that the services you received at the

No-Show & Late Cancellation Fees
Non-Medicaid Patients

For patients not enrolled in New York State Medicaid/Medicaid Manage Care:

A $25 no-show or late cancellation fee will be charged for:

- Appointments cancelled with less than 24 hours' notice.
- Failure to arrive for a scheduled appointment without notice.

- This fee is not billable to insurance and is the patient's responsibility.
- The $25 fee must be paid at next appointment.
- No-shows or late cancellations may result in scheduling restrictions or dismissals from practice.

Important Additional Notes

- Arriving more than 15 minutes late may be considered a no-show at the discretion of the practice.
- This policy applies equally to all non-Medicaid patients regardless of insurance type.

Signature_____

Medicaid Patients – No-show Policy

Patients enrolled in New York State Medicaid will not be charged a no-show or late cancellation fee for Medicaid-covered services, in accordance with Medicaid regulations.

However, repeated missed appointments, late cancellations, or no-shows may result in dismissal from the practice, even though no fee is charged.

To ensure fair access to care for all patients:

- Medicaid patients with repeated no-shows may have appointment scheduling restrictions, or
- May be dismissed from the practice following written notice and in compliance with New York State continuity-of-care requirements.

Important Additional Notes

- Arriving more than 15 minutes late may be considered a no-show at the discretion of the practice.
- This policy applies equally to all non-Medicaid patients regardless of insurance type.

Signature: _____