ANTHEM DENTISTRY

Patient Information

Please Print

Title: First Name: Middle: Last:

Preferred Name: Marital Status:

Address: City: State: Zip:

Cell Phone: Home Phone: Work Phone:

Patient Social Security #: Patient Date of Birth: Sex: ☐ M ☐ F

Email Address: May we contact you by email? ☐ Yes ☐ No

Emergency Contact: Phone:

How did you hear about us?

**If patient is under the age of 18, Parent or Guardian please fill out below:*

Parent / Guardian Name:

Date of Birth: Social Security #:

Insurance Information

Do you have Dental Insurance? ☐ Yes ☐ No

Primary Insurance	Secondary Insurance
Subscriber Name:	Subscriber Name:
Subscriber SSN:	Subscriber SSN:
Date of Birth:	Date of Birth:
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name:	Employer Name:
Employer Phone:	Employer Phone:
Insurance Company:	Insurance Company:
Insurance Group #	Insurance Group #
Insurance Phone #	Insurance Phone #
Insurance Address:	Insurance Address:

Please present insurance card and Drivers License

AUTHORIZATION TO RELEASE & DISCUSS DENTAL INFORMATION FORM

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, insurance providers and primary care doctors, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below.

Authorization to Speak with Family/Friend (including spouses)

I give the following named person(s) authorization to take messages or speak with the office of Anthem Dentistry on my behalf regarding (please check all items authorized):

Name of Authorized person: _____ Relationship: _____

Phone Number: _____

☐ Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance ☐ Other

Name of Authorized person: _____ Relationship: _____

Phone Number: _____

☐ Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance ☐ Other

I understand my express consent is required to release my health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record, and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed below.

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Notice of Privacy Practices

Federal & State laws require Anthem Dentistry to maintain the privacy of all patient healthcare information. Furthermore, we are required by law to provide all parents or legal guardians with this notice reviewing our privacy practices, our legal obligations, and your rights in regard to your child's healthcare information. Anthem Dentistry must follow the privacy practices as described within this notice while this policy is in effect. This notice takes effect on February 1st, 2008 and will remain in effect until replaced, amended, or eliminated.

Anthem Dentistry reserves the right to change these privacy practices and the terms of this notice at any time provided such applicable laws permit such changes. We reserve the right to make any needed changes to our privacy practices and these new terms will be effective for all health information that we maintain, including health information we create or receive before such made changes. Before we make any significant changes to our privacy practices, we will change this notice and make new notice available upon request.

Parent or legal guardians may request a copy of this notice, at any time. For additional information about our privacy practices or to review our company's Health Insurance Portability & Accountability Act (HIPAA) Manual, please contact our office at any time.

USES & DISCLOSURES OF HEALTHCARE INFORMATION

Anthem Dentistry will use and disclose patient healthcare information during your treatment, while obtaining payment from insurance companies and during general healthcare operations. For example:

Treatment. Anthem Dentistry may use your health information during direct treatment or by disclosing such information to other dentists, physicians or healthcare providers who may provide specialized treatment for you.

Payment. We may also use and disclose your health information to obtain payment for services rendered. We may disclose your healthcare information to another healthcare provider or entity that is also subject to these same federal & state privacy rules and regulations for payment activities.

Healthcare Operations. We may use and disclose your healthcare information during our routine healthcare operations. Healthcare operations may include quality assessments and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, and certification, licensing, or credentialing activities. We may disclose your healthcare information to another healthcare provider or organization that is subject to the same federal & state privacy rules and regulations and that has a relationship with you during the support of healthcare operations. We may disclose your information to help such organizations conduct quality assessment and improvement activities, review the competence or qualifications of healthcare professionals, or detect or prevent healthcare fraud or abuse.

On Your Authorization. You may give Anthem Dentistry written authorization to use your healthcare information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any issues or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your healthcare information for any reason except those described within this notice.

To Your Family & Friends. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for previously performed healthcare services. Before we disclose your health to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event you are incapacitated and cannot make a decision for yourself, or in the event of an emergency, we will disclose your medical information based on our professional judgment of practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical/dental supplies, radiographs or other similar forms including health information. We may also use or disclose information about you to notify or assist in notifying a person involved in his/her care.

Appointment Reminders. Anthem Dentistry may use or disclose your healthcare information to provide you and your family with appointment reminders. (Such as: telephone calls, voice messages, postcards, or letters)

Disaster Relief. We may use or disclose your healthcare information, as authorized by federal or state law for the following purposes deemed to be in the public's best interest or benefit:

- As required by law
- For public health activities, including disease and vital statistic reporting, reporting child abuse or neglect, FDA oversight and to employer's regarding work-related illness or injury.
- To health oversight agencies
- In response to court and administrative orders and lawful processes

- To law enforcement officials pursuant to subpoena and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and for purposes of identifying or locating a suspect or other persons.
- To coroners, medical examiners and funeral directors
- To an organ procurement organization
- To avert serious threat to health or safety
- In connection with certain research activities
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities
- To correctional institutions regarding inmates
- As authorized by state worker's compensation laws

PATIENT or PARENT/LEGAL GUARDIAN RIGHTS

Access. You have the right to look at or receive a copy of your health information, with limited expectations. You may request that we provide a copy in format other than photocopies. We will use the format you request unless we cannot practically do so. You must make all requests in writing to obtain access to your child's healthcare information. You may request access by sending us a letter. If you request a copy, we will charge you a reasonable fee, which may include labor, copying costs and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may, but are not required to, prepare a summary or an explanation of your health information for a fee.

Disclosure Accounting. You have the right to receive a list of instances in which Anthem Dentistry or any business associates disclosed your health information over the past year (but not prior to June 24th 2010). That list will not include disclosures for treatment, payment, healthcare operations, as authorized by you and certain activities. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction. You have the right to request that we place additional restrictions on the use or disclosure of your healthcare information. We are not required to agree with such additional restrictions, but if we do, we will abide by our agreement (except in the event of an emergency). Any agreement we make to a request for additional restrictions must be in writing and signed by our privacy officer. Your request is not binding unless our agreement is in writing.

Alternative Communication. You have the right to request that we communicate with you about your health information by an alternative means or at an alternative location. You must make your request in writing. You must specify in your request the alternative means or location and satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment. You have the right to request that we amend your healthcare information. Your request must be in writing and should explain why you are requesting this amendment. We may deny your request under certain circumstances.

QUESTIONS OR COMPLAINTS

If you need additional information regarding our office's Privacy Practices & Regulations or have specific questions or concerns, please feel free to contact us. Furthermore, if you believe that:

- We may have violated your privacy rights
- We made a decision about access to your health information incorrectly
- Our response to a previous request to amend or restrict the use or disclosure of your information was incorrect
- We should communicate with you by alternative means or an alternative location

You may submit a written complaint with our privacy officer or directly to the US Department of Health & Human Services. We will provide you with these addresses to file your complaint, upon request. We support your right to the privacy of your child's health information. We will not retaliate in any way if you choose to file a complaint with us or the US Department of Health & Human Services.

I understand the contents of the previous notice concerning the privacy of my confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Anthem Dentistry from selling or transferring this information to any unauthorized locations without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

Signature of Patient/ Parent or Guardian	Date

Dental Practice Policies and Financial Agreement

Anthem Dentistry
Anthem Dentistry
3668 W Anthem Way #162
Phoenix, AZ 85086
(623) 551-7500
dentistry.anthem@gmail.com

Patient Name: _____

Date of Birth: _____

Responsible Party/Guardian: _____

Relationship to the patient: _____

Signature: _____

Date: _____

Welcome

Welcome to Anthem Dentistry. We appreciate the opportunity to provide you with quality dental care. To ensure clear communication and efficient service, please review the following policies carefully.
Your signature below confirms your understanding and agreement.

Appointments & Missed Appointments

We reserve time specifically for you. If you are unable to keep your scheduled appointment, please provide at least **48 business hours' notice**.
Failure to provide proper notice or failure to appear for a scheduled appointment may result in a broken appointment fee as follows:

- **Missed appointment with the Dentist: $100.00**
- **Missed appointment with the Hygienist: $50.00**

Repeated missed appointments may result in dismissal from the practice.

We make every effort to run on time. If you arrive more than **15 minutes** late, we may need to reschedule your appointment.
Occasionally emergencies arise that cause delays. We respect your time and will make every effort to stay as close to your appointment time as possible.

Payment Policy

Payment is due at the time services are rendered unless prior arrangements have been made.
We accept cash, debit cards, and major credit cards.
If you have dental insurance:

- We will submit claims as a courtesy.
- Insurance is a contract between you and your insurance carrier.
- Estimated patient portions are due at the time of service.
- Any balance not paid by insurance within **60 days**, for any reason, becomes the responsibility of the patient.

Once insurance payment is received, any remaining balance will be billed to you. Payment of outstanding balances is due in accordance with Anthem Dentistry's financial policy.
If insurance claims remain unpaid, it is the patient's responsibility to follow up with the insurance carrier. The office will continue to assist with claim processing as a courtesy.
Returned checks may be subject to a fee in accordance with office policy and applicable law.
Accounts not paid as agreed may be subject to interest or finance charges as permitted by applicable law and office policy.

Past Due Accounts

Accounts that remain unpaid beyond **90 days** may be referred to a collection agency.
If your account is referred to collections, you agree to be responsible for collection fees permitted by applicable law, as well as reasonable attorney fees and court costs if applicable.

Treatment Estimates

Any fee estimate provided is not a guarantee of insurance payment.
Actual coverage is determined solely by your insurance carrier. You are responsible for all services rendered, regardless of insurance benefits.

No Guarantee of Results

Dentistry is not an exact science and results cannot be guaranteed. No guarantee or assurance has been made regarding the outcome of treatment you have requested or authorized. Each dentist is an individual practitioner and is solely responsible for the dental care rendered.

Records Requests

Original records remain the property of the practice.
Upon written request, copies of records will be provided within the timeframe required by state law. A reasonable duplication fee may apply where permitted.

Arbitration Agreement

Patient Initials: _____

The patient and dentist (including their corporations, representatives, staff, agents, parents, guardians, children, and all related individuals and entities) agree that all disputes arising from events that occurred in the dental office will be determined through submission to an arbitrator, and not by a lawsuit or other legal proceeding filed in a federal, state, county, or municipal court.
By signing this Arbitration Agreement, the parties waive and forfeit their constitutional, statutory, or common law rights for a judge or jury to decide disputes, and instead accept the use of a private arbitrator. This Arbitration Agreement covers all disputes related to dental treatment, financial matters, or any other events that occurred in the dental office—whether in tort (intentional or negligent), contract, statute, common law, or otherwise—including, without limitation, actions relating to dental negligence, return of fees, loss of consortium, wrongful death, discrimination, emotional distress, or punitive damages.
The arbitration shall bind all parties, including any spouse or heirs, and will not be subject to court review. Either party may initiate arbitration by serving on the other a written “Demand for Arbitration” by certified mail (no other form of service will be acceptable). The Demand for Arbitration must identify all parties, include contact information, describe the claims against each party, and state the amount of damages sought. Either party may continue the proceedings by contacting the American Arbitration Association (AAA). A single AAA arbitrator, mutually selected by the parties, will conduct the arbitration. Proceedings will be resolved using AAA rules. **The laws of the state in which services are rendered will apply.** If any provision of this agreement is held invalid or unenforceable, the remaining provisions remain in full force and effect.

Acknowledgment & Signature

I have read, understand, and agree to the policies outlined above. I acknowledge that I have had the opportunity to ask questions.

ADA American Dental Association®

Today's Date: _____

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Mailing Address:	City:	State: Zip:
Date of Birth: / /	Gender:	
Occupation:		
Emergency Contact: Name:	Relationship:	Phone:

If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? / / What was done at that appointment?

When was the last time you had dental x-rays taken?

Please mark an "X" in the box ONLY if this applies to you.

Is it hard to open your mouth? ☐
Does it hurt to chew, bite or swallow? ☐
Do your gums bleed when you brush or floss your teeth? ☐
Have you ever had periodontal (gum) treatments like scaling and root planing? ☐
Do you have, or have you ever had, any sores or growths in your mouth? ☐
Do you clench or grind your teeth? ☐
Does your jaw click, pop or hurt? ☐
Do you have earaches or neck pains? ☐
Does dental treatment make you nervous? ☐
Have you ever experienced any of these sleep-related breathing disorders? ☐
☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

Have you ever had a serious injury to your head or mouth? ☐
If yes, please describe what happened and when it happened: _____

Have you ever had problems with dental treatment in the past? ☐
If yes, please describe what happened: _____

Have you ever had a reaction to, or problem with, dental anesthesia? ☐
If yes, please describe what happened: _____

Are you unhappy with your smile? ☐
If yes, why? Please mark all that apply:
☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth
☐ Other. Please describe: _____

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions. **Yes No ?**

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ ☐ ☐
If yes, what medication are you taking? _____

Are you taking any medication to treat **osteoporosis** or Paget's disease? ☐ ☐ ☐
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®).
If yes, what medication are you taking? _____

Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zometa®).
If yes, what medication are you taking? _____ How many years have you been taking it? _____

Are you taking **hormonal replacements**? ☐ ☐ ☐

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)? ☐ ☐ ☐

Do you use **vaping products**? ☐ ☐ ☐

How many **alcoholic beverages** do you have per week? _____

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? ☐ ☐ ☐
If yes, what substances? _____ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally
Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? _____

Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements**? ☐ ☐ ☐
If yes, please list them here and include information about how much and how often you use each one. _____

Do you use **GLP-1 Glucagon-Like Peptide-1 medication**? ☐ ☐ ☐

WOMEN ONLY: Are you:

Taking **birth control pills**? ☐ ☐ ☐

Pregnant? If yes, number of weeks: _____ ☐ ☐ ☐

Nursing? If yes, number of weeks: _____ ☐ ☐ ☐

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ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:	Yes	No	?
Aspirin	☐	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Hay fever/seasonal allergies	☐	☐	☐
Iodine	☐	☐	☐
Latex (rubber)	☐	☐	☐
Local anesthetics	☐	☐	☐
Metals	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix)	☐	☐	☐
Other	☐	☐	☐

Please describe any "Yes" answers and include information about your experience.

_____

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure (systolic, diastolic)?

Doctor's Name:

Phone:

Please use an "X" to mark your answers to the following questions.

	Yes	No	?
Are you in good physical health?	☐	☐	☐
Are you currently being seen or treated by a physician?	☐	☐	☐
Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done?	☐	☐	☐
Have you had a **serious illness, operation or been hospitalized** in the past 5 years?	☐	☐	☐
Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	☐	☐	☐
Have you had a **heart valve replacement or heart surgery**?	☐	☐	☐
Have you had an **organ or bone marrow/stem cell transplant**?	☐	☐	☐
Have you traveled internationally within the last 30 days	☐	☐	☐
Have you had a fever (100.4°F or above) in the last 72 hours?	☐	☐	☐

If you answered yes to any of the above, please explain: _____

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

	Yes	No	?
Heart (Cardiac) Health			
Pacemaker/implanted defibrillator	☐	☐	☐
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Coronary artery disease	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur/rhythm disorder	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Stroke	☐	☐	☐
Breathing (Respiratory) Health			
Asthma (COPD)	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer	☐	☐	☐
Type: _____			
Date of diagnosis: _____			
Chemotherapy: _____			
Radiation treatment: _____			
Blood (Circulatory) Health			
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
High or low blood pressure	☐	☐	☐
Brain (Neurological)/Mental Health			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Epilepsy	☐	☐	☐
Mental health disorders	☐	☐	☐
Neurological disorders	☐	☐	☐
Post-traumatic stress disorder	☐	☐	☐
Traumatic brain injury or concussion	☐	☐	☐
Autoimmune Disease			
AIDS or HIV Infection	☐	☐	☐
Lupus	☐	☐	☐
Digestive Health			
Gastrointestinal disease	☐	☐	☐
G.E. reflux/persistent heartburn (GERD)	☐	☐	☐
Stomach ulcers	☐	☐	☐
Eye (Vision) Health			
Glaucoma	☐	☐	☐
Other			
Arthritis	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes (type I or II)	☐	☐	☐
Eating disorder	☐	☐	☐
Frequent infections	☐	☐	☐
Type of infection: _____			
Hepatitis, jaundice or liver disease	☐	☐	☐
Immune deficiency	☐	☐	☐
Kidney problems	☐	☐	☐
Malnutrition	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Sexually transmitted infection (STI)	☐	☐	☐
Thyroid problems	☐	☐	☐

Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes	No	?
had pain or tightness in the chest?	☐	☐	☐
coughed up blood or had a cough that lasted longer than 3 weeks?	☐	☐	☐
been exposed to anyone with tuberculosis?	☐	☐	☐
had a rapid or irregular heart beat?	☐	☐	☐
found it hard to catch your breath?	☐	☐	☐
had a high fever (greater than 101.5˚F) for no reason?	☐	☐	☐
noticed a change in your vision?	☐	☐	☐
fainted for no reason?	☐	☐	☐
experienced vomiting, diarrhea, chills, night sweats or bleeding?	☐	☐	☐
had migraines or severe headaches?	☐	☐	☐
Over the past two weeks, have you felt connected to the world around you?	☐	☐	☐

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.
I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____

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Oral Cancer Screening Consent Form

We are very concerned about oral cancer, and conduct screening examinations on every patient.

The incidence of Oral Cancer continues to rise in the USA. Approximately 45,750 people in the US will be newly diagnosed with oral cancer every year and one American dies every hour of every day. **Alarmingly, 25% of the new oral cancer cases are people that do not have any of the traditional lifestyle risk factors, such as age and tobacco and alcohol use. Exposure to HPV (Human Papillomavirus) is a newly discovered risk factor.**

Traditionally, dentists and hygienists have done oral cancer screening with the naked eye, but **VELscope** (Visually Enhanced Lesion scope) **will help us pinpoint and identify suspicious tissue at earlier stages before they may become life threatening concerns.**

VELscope, similar to other early detection procedures like colonoscopy,mammography, PAP smear and PSA exam, is a painless non-invasive blue light that is shined into the patient's mouth. The images are viewed through the back of the VELscope handpiece and the dentist may find tissue abnormalities at an earlier stage. Before the exam, the room is darkened much like "desert storm night vision technology" ; the clinician can see changes in tissue that may not be visible. These detected changes can range from something minor to something of greater concern that may require further examination and follow up.

The VELscope testing is an addition to our traditional visual oral cancer screening and will add only a few minutes to the entire exam. However, the VELScope exam may or may not be covered by dental insurance. The fee for this enhanced examination is $20.00. As part of our standard of care and because we care about you, we strongly recommend that you choose this additional screening procedure.

***Please sign this document to accept /not accept the financial responsibility for this procedure.**
Once again, we feel this breakthrough technology is very important to the enhanced quality of care we can offer to our patients.

Thank you for your kind consideration.

- ☐ **YES, I authorize the office to perform the VELscope examination.**
- ☐ **NO, I understand the risks and choose not to have the VELscope examination.**

Print Name _____

Signature _____ Date _____

Pharmacy Information

We are updating our records and need to have your pharmacy information so all of the prescriptions we write for you will be sent directly to your pharmacy.

Patients Name:

DOB:

Pharmacy Name:

Pharmacy Address:

Pharmacy Phone Number:

Thank You Anthem Dentistry