



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. **Alarminglly, 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