

UPDATED HEALTH INFORMATION/INSURANCE UPDATE

NAME _____ DATE _____

Any change in Residential Address, please update _____

PLEASE READ: *X-rays are standard procedure during your dental checkup visit to diagnose decay or bone loss that cannot be seen on visual exam and are recommended every six months. Due to changes in some dental insurance policies some patients may have a payment for x-rays. Copays provided are ESTIMATES ONLY, please call your insurance provider to verify your copays and coverage limitations. Please ask front desk if you have any questions.*

ARE YOU TAKING ANY MEDICATIONS? **YES** / **NO**

If so what medications are you taking: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis |
| _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors |
| _____ | <input type="checkbox"/> Growths | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | Due | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries | date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | Treatment | OTHER: |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory | <input type="checkbox"/> |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood | Problems | _____ |
| <input type="checkbox"/> Diabetes | Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Problems | |

• Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

• Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Date: _____

Early Detection Is The Key To Saving Lives

We have incorporated **VELscope** into our oral screening standard of care. We find that using VELscope for an oral cancer examination improves the ability to identify suspicious areas at their earliest stages. **VELscope is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA and is recommended once a year by the American Cancer Society.** VELscope is a simple and painless examination that gives the best chance to find any oral abnormalities at their earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life.

The VELscope exam will be offered to you annually.

I AM INTERESTED DO LET ME KNOW MORE ABOUT IT

YES _____

NO _____

SIGN _____

DATE _____



We feel that every patient in our practice deserves to have a smile they can be proud of. We are excited to offer our patients a unique program we call **Whitening for Life.**

When you come to our office for your preventive examination, x-rays and cleaning, we will provide you with custom bleaching trays and materials for a one-time enrollment fee of \$99 (This is a savings of \$400!) Then, at each recommended preventive visit, we will give you a complimentary touch up kit of bleaching gel. This ensures that you will be able to keep your teeth bright and beautiful for life!

I AM CURIOUS DO LET ME KNOW MORE ABOUT IT.

YES _____ **NO** _____

SIGN _____ **DATE** _____