# *WELCOME!*

***Please Tell Us About Yourself...***

**L1**

**We hope you will find this to be a special place for your dental care.**
All information is held in strict medical privacy.

Date Today_____ Birth Date_____

Name_____ _____ _____ _____
(Last) (First) (Initial)

Preferred First Name_____ SSN_____-____-_____ Spouse's Name_____

Address_____City_____Zip_____

Are you working? Y N Employer _____Your Position_____

**Communication with you for appointments is very important. Help us by providing your email address and circle the best-to-reach phone.**

PHONES work_____ Home_____ Cell_____

Email address_____ Pager _____ Other_____

How can we help you today? _____ Have you ever considered bleaching, bonding, or braces? N Y

How did you come to know about our office? _____Who may we thank?_____

In choosing a dentist, what is important to you?

_____

Have you ever had a bad dental experience? N Y What? _____

Name of a relative not living with you_____ Phone_____

## Regarding Your Account Information...

PERSON RESPONSIBLE FOR PAYMENT (other than dental insurance) **Self** or_____

ADDRESS (if not you)_____City _____Zip_____

PHONES - Work_____ Home_____ Cell_____

## We Need Your Consent...

1. I hereby give my consent to the doctor and his chosen assistants to take **necessary x-rays** or make **study models,** as needed, in order to make a **thorough diagnosis** of my dental condition.
2. I also authorize the doctor to perform recommended treatment, agreed to by me, in a manner that meets the official standard of care. I understand that using **local anesthetic** agents embodies a certain level of risk.
3. I understand that **I am ultimately responsible for payment** of all dental services not covered by dental insurance and that finance charges and collection fees may be involved should my payment be delayed and a collection agency used.
4. I understand and agree that, where and when appropriate, **credit bureau reports** may be obtained.
5. I hereby give Vegas Smiles and Dr. Gussow permission to use my photos to help other patients understand treatment options. ___Y ___N

***"I understand and agree to accept all of the above."***

*Signature:* _____ *Date:* _____

## *Medical Health...*

YOUR PHYSICIAN_____ PHONE_____

Have you been under physician's care or been hospitalized within the past two (2) years? _____ N Y

If yes, why

_____

Are you currently taking any pills or medications at all? _____ N Y

1._____ for treatment of _____ how long?_____

2._____ for treatment of _____ how long?_____

3._____ for treatment of_____ how long?_____

**Note: There are more medications on the accompanying list. N Y**

Are you **ALLERGIC** to any medication, such as penicillin or aspirin? _____ N Y

Do you require **ANTIBIOTIC PREMEDICATION** before dental work? _____ N Y

Have you had **HEPATITIS**, TYPE A (from food) or TYPE B (blood, serum) or TYPE C (unknown cause)? _____ N Y

Do you have, or suspect you have **AIDS**, or have you tested positive for **HIV**? _____ N Y

(Women) Are you currently pregnant? N Y If yes, what month? _____

**Circle "Y" if YES and give year if you have had any of the following...**

| | | | |
|---|---|---|---|
| Diabetes?, Low Blood Sugar? | Y _____ | Rheumatic Fever? | Y _____ |
| Delayed Wound Healing?, Unusual Bruising? | Y _____ | High Blood Pressure? | Y _____ |
| Abnormal or Prolonged Bleeding? | Y _____ | Recurring Headaches?, Migraines? | Y _____ |
| Anemia?, Any Blood Disorder? | Y _____ | TMJ (Jaw Joint) Pain, Jaw Clicking? | Y _____ |
| Ulcers?, Digestive Problems? | Y _____ | High Stress at Work or Home? | Y _____ |
| Kidney Disease? or Kidney Trouble? | Y _____ | Unusual Weight Gain or Loss? | Y _____ |
| Asthma?, Breathing or Lung Problems? | Y _____ | Arthritis? | Y _____ |
| Drug or Alcohol Addiction? | Y _____ | Cancer? | Y _____ |
| Artificial Joint(s)? | Y _____ | Depression? | Y _____ |
| Heart Attack?, Mitral Valve Prolapse? | Y _____ | Epilepsy? Seizures? | Y _____ |
| Heart Murmur with Regurgitation? (noise) | Y _____ | Nervous Breakdown? | Y _____ |

**Do you have ANY other medical condition not mentioned above?** NO YES _____

_____

**Dental Insurance...** Yes No **Insurance Plan**_____
EMPLOYER PROVIDING INSURANCE _____
ENROLLED EMPLOYEE: SELF or _____

EMPLOYEE SSN _____-_____-_____ BIRTHDATE _____

**Secondary Dental Insurance...** Yes No **Insurance Plan** _____
EMPLOYER PROVIDING INSURANCE _____
ENROLLED EMPLOYEE: SELF or _____

EMPLOYEE SSN _____-_____-_____ BIRTHDATE _____

Vegas Smiles

# VELscope Oral Cancer Consent Form

As a healthcare provider, we continually review new medical technologies looking for those procedures that represent the latest advances in medical care for our patients. We are concerned about oral cancer and look for it in every patient. The incidence of oral cancer continues to rise in the USA. Common names for it include such things as mouth cancer, tongue cancer, tonsil cancer, and throat cancer. Approximately 49,750 people in the US will be newly diagnosed with Oral cancer in 2017 and one American dies every hour because of it. While some think this is a rare cancer, mouth cancers will be newly diagnosed in about 132 new individuals each day in the US alone, and a person dies from oral cancer every hour of every day. Alarmingly, 25% of the new oral cancer cases are people who do not have any of the traditional lifestyle risk factors, such as age, tobacco, and alcohol use.

VELscope (Visually Enhanced Lesion Scope) will help us pinpoint and identify suspicious tissue at earlier stages before they may become life threatening concerns. This technology has successfully improved the identification of pre-cancerous abnormalities in thousands of exams and is similar to other early detection procedures such as mammography, pap smear, and a colonoscopy.

This examination is not a new procedure and insurance may cover some of the procedure cost. There is a fee of **$15** for using this tool to aid in the examination of your oral tissue. As part of our standard of care and because we care about you, we have made it our policy to have a VELscope examination performed once a year for each patient over the age of 18.

**Please check off one:**

☐ Yes, I authorize my hygienist to use the VELscope along with my conventional visual oral examination.

I accept financial responsibility today, for this enhanced visual examination if the procedure is not covered under my insurance.

☐ No, I understand the risks and choose not to have the VELscope examination.

**PRINT NAME:** _____

**SIGNATURE:** _____ **DATE:** _____

Vegas Smiles

# KEEPING APPOINTMENTS

We try to provide appointment times that best suit your needs. The time is reserved for you and you alone.

When you confirm your appointment a day or two before, you are making a commitment that we expect you to honor.

Now we do understand that life is sometimes unpredictable and may throw off your timing. While we empathize with unexpected events, we are left with vacant time if you fail to show up or cancel the same day.

We now have a rescheduling fee for the following situations:

1. **CONFIRMED APPOINTMENTS**: "No Show" OR Cancellation within 24 hours - **$25** per hour.
2. **UNCONFIRMED APPOINTMENTS:** (If you fail positively respond to our calls, emails, or texts) Your time will be given to someone else. You will need to reschedule, but there will be no fee.
3. **IF YOU ARE MORE THAN 15 MINUTES LATE:** It will be treated as a "NO SHOW" with the need to reschedule and pay the fee.

**I AGREE TO THE ABOVE STIPULATIONS:**

NAME: _____

SIGNATURE: _____ DATE: _____