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:

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

OTHER:

- ☐ _____
- ☐ _____

- 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.

_____ Date: _____
Signature of patient, parent or guardian

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 the irearliest 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**_____

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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 $199. Then, at each 6 months recommended preventive visit, we will give you one complimentary touch up whitening syringe. Any default on the 6 months clause will incur $25 fee for the whitening syringe. This ensures that you will be able to keep your teeth bright and beautiful for life!

All we ask in return is:

- Y**ou keep your six month preventive visits current**. Your long term dental health is as important to us as it is to you. Our patients have found that these six month visits help greatly reduce emergencies. That is why we are happy to provide this extra bonus for our patients who are committed to their dental health.
- **Provide at least 48 hours notice** if you need to cancel or change an appointment. In order to provide exceptional services like Whitening for Life to all of our patients, we ask that you give us the courtesy of advance notice for schedule changes.

We appreciate the opportunity to serve you, and look forward to seeing your bright smile for many years to come!

I understand the Whitening for Life program requirements, and would like to enroll

Name:_____

Signed:_____

Date:_____

*** Your Whitening for Life membership is valid as long as Dr. Rane retains her private practice in dentistry.**