

Vivian Medina, D.D.S.

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Last Name _____ First Name _____ Middle Initial _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Home # _____ Cell # _____ E-Mail _____

Preferred Method of Contact between 8:00 a.m. & 5:00 p.m.: E-Mail/ Home Phone/ Cell Phone/ Work

SYMPTOMS *circle all that apply*

Headaches	Facial Pain	Difficulty Swallowing
TMJ pain/Noise	Sensitive Teeth	Loose tooth
Limited Opening	Difficulty Chewing	Clenching
Ear Congestion	Neck Pain	Hot/Cold Sensitivity
Dizziness	Postural Problems	Insomnia
Ringling In Ears	Tingling In Fingers	Back Pain
Bell's Palsy	Trigeminal Neuralgia	Snoring

MEDICAL HISTORY *circle all that apply*

Heart Murmur	Artificial Joint Replacement	Blood Disease
Angina/Chest Pain	Pins	Bleeds Easily
Heart Attack/Failure	Asthma	HIV/AIDS
Congenital Heart Disease	Sinus Problems	Hepatitis (A,B, or C)
Mitral Valve Prolapse	Lung Disease	Venereal Disease
Rheumatic Fever	Kidney Disease	Cancer
Heart Pace Maker	Liver Disease	Thyroid Problems
Artificial Heart Valve	Diabetes	Tuberculosis
Irregular Blood Pressure	Fever Blister/Cold Sore	Allergies

Other? _____

Are you allergic to any medications? **YES NO** *if yes, please explain the reaction* _____

Do you use recreational drugs? **YES NO** *if yes, please explain* _____

Do you smoke or chew tobacco? **YES NO** *if yes, please explain* _____

Are you under a physician's care? **YES NO** *if yes, please explain* _____

Are you taking any medications? **YES NO** *if yes, please explain* _____

Are you taking any supplements? **YES NO** *if yes, please explain* _____

Are you taking any over the counter medications? _____

Have you had an adverse reaction to local anesthetic? **YES NO**

if yes, please explain _____

Are you pregnant? **YES NO** Normal Blood Pressure _____

Have you ever been diagnosed with sleep apnea? **Yes No**

X _____ **Date** _____

Oral Cancer Screening Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but more than 25% of oral cancer victims have no such lifestyle risk factors. Studies also suggest that human papillomavirus (HPV) plays a role in more than 20% of oral cancer causes.

* Oral cancer risk by patient profile as follows:

Increased risk:	patients ages 18-39 & sexually active patients (HPV)
High risk:	patients age 40 and older; tobacco users (ages 18-39, any type within 10 years)
Highest risk:	patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

In our practice, as your healthcare provider, we seek to provide you access to the newest and most effective scientific screening and treatment. In 2009 the StarDental® Identafi® system was introduced. This multispectral medical device greatly enhances our ability to find early signs of cancer and dysplasia in the mouth. Historically our practice has used white light in examination for oral cancer. The use of narrow band violet light and green-amber reflected light helps us detect in the oral tissue various problems including cancer lesions and dysplasia.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is \$80.

Yes. I authorize the clinician to perform the oral cancer screening. I accept financial responsibility for this enhanced examination if my insurance company does not currently cover this procedure.

Print Name: _____

Signature: _____ Date: _____

No. I would prefer not to have an oral cancer screening at this time.

Print Name: _____

Signature: _____ Date: _____