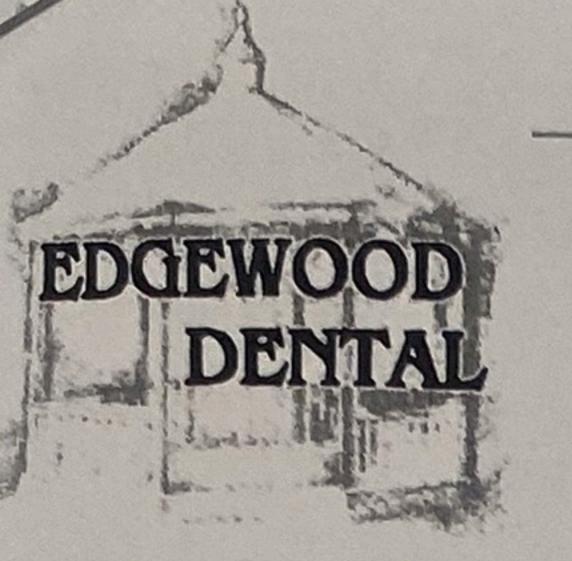
Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:	Date of Birth:
I have been given a copy of Edgewood Dental, which describes how my health information is use has the right to change this <i>Notice</i> at any time. I Practice Privacy Officer.	ed and shared. I understand that the Practice
My signature below acknowledges that I have I Privacy Practices:	been provided with a copy of the Notice of
Signature of Patient or Personal Representative	Date
Print Name	
Personal Representative's Title (e.g., Guardian, Health	Care Power of Attorney)
For Facility Use Only: Complete this section ture. If the patient or personal representative is unable the Acknowledgement is not signed for any other research.	or unwilling to sign this Acknowledgement, or
Completed by:	
Signature of Practice Representative	Date
Print Name and Title	
File Original in Patient's Health Care Record	





301 Oxford Valley Road Suite 1105A Yardley, PA 19067

> Phone: 215.493.7000 Fax: 215.493.7002

Dear valued Patient:

It is our goal to provide our family of patients with the highest degree of care. Therefore, we are making available to you, oral cancer detection with *VELscope*. VELscope is a system currently being used to diagnosis early stages of oral cancer. In most cases by the time lesions are visually detected they are in stage III or IV and patients usually do not have positive prognosis. Healthcare institutions across the country are verifying the positive diagnostic results of the VELscope. It is a simple non-invasive tool that is used in conjunction with the visual inspection done at your preventive visit every six months. We recommend VELscope testing on an annual basis; unless a patient has suspicious lesions then more frequent testing would be recommended. Early detection is saving lives. Studies have shown that you do not need to be a smoker or drinker to have oral cancer.

Since most insurance companies are not up to date on the most recent diagnostic services available they have not yet recognized the use of the VELscope for oral cancer examination. Patients choosing to have the procedure will be responsible for the \$39 evaluation fee. Whether or not you elect to have the VELscope examination, we ask that you kindly check the box below and remit with your signature.

O I would app	reciate the VELscope examination.
O I do not war	nt the VELscope examination.
Signed:	Date:
Update:	
- Aggst	
Date:	Accept O Decline Signed:
Date:	OAccept ODecline Signed:
Date:	O Accept O Decline Signed:
Date:	OAccept ODecline Signed:

PATIENT REGIS	TEANTION				DATE:			
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ADDRESS:	FIRST		M					
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EMPLOYER:		FUĻ		DENT O SC	CHOOL ATTE		DDRESS	
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PERSON RESP		NAME: _ ·						
FOR ACCC	UNT	State Driver's	License Nur	nber:				
ACCOUNT & IN	CHEANCE				!			
REGISTRA	87/92/97/99/97			(FILL IN	BOTH BLOC	KS)		
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ADDRESS:	LACT	FIDOT			1.07	\		
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DENTAL	EMPLOYER			EMPLO	OYER			
INSURANCE CO:	DENTAL INSURANCE		GROUP	DENT	AL INSURANCE		ODOLID.	
GROUP #:	DEIVINE BOOKSHOE		dicor	OEN,	C INSUITABLE		GROUP€	
PERSON TO CONTAC	T OUTSIDE OF	NAME:				TEL	_#	
IMMEDIATE FAMILY IN CASE OF EM	HOUSEHOLD	ADDRESS:	LAST	FIRST		M		
			STREET		CITY		STATE	ZIP=
AUTHORIZA	TION							
4011101112								
I hereby authorize paymen	nt directly to the De	ntal Office of the	e group insura	ance benefits	otherwise pay	able to me.	I understand	that I am
therapeutic procedures as i	dental treatment, i ni	ereby authorize t	ne Dental Offic	e to administe	r such medica	tion and nort	orm auch die	
of my knowledge.								
SIGNATURE OF RESP	ONSIBLE PARTY	Scriedule idi	nake appointmen	nt changes, unle	inges in youi	cv arises A m	sufficient time to it affect many inimum of \$75.0	
X					Date:			
☐ Adult Patient	☐ Husband (or Fat	ther) 🗆 Wife	(or Mother)	" □ Guardia				
								•
THE RESIDENCE OF THE PARTY OF T								1

ATIENT NAME			DATE				
Pharmacy Name:	First	First M Phone:					
				PLEASE CIRCL			
DENTAL HISTORY:	le breathing when you sleen?			YES NO			
Do you snore or have trouble breathing when you sleep? Do you have a specific dental problem? Describe							
Do you have dental examinations on a routine basis? Last exam & X-ray							
	resent dental health as good? Co			YES NO			
o you think you have activ	re decay or gum disease? Do yo	ur gums ever bleed?		YES NO			
o you have any dental imp				YES NO			
	a routine basis? Discuss			YES NO			
	having dental treatment?	noribo		YES NO			
you want to keep your r	xperience in a dental office? Des	scribe		YES NO			
you like your smile? Wh				YES NO			
ame of your previous den				YES NO			
you ever brux or grind y	DESCRIPTION OF THE PROPERTY OF			YES NO			
	ontic treatment (tooth straightening	COLUMN TO A STATE OF THE PARTY		YES NO			
	popping or discomfort in the jaw			YES NO			
	cing your existing silver fillings w	ith white?					
EDICAL HISTORY:	ddenaa			YES NO			
edical doctor's name & A re you under a doctor's c				YES NO			
	d or received a blood transfusior	2 When?		YES NO			
	itions, pills, or drugs? What?			YES NO			
Heart Trouble High Blood Pressure Low Blood Pressure Heart Murmur Rheumatic Fever Congenital Heart Lesion Artificial Heart Valve Heart Pacemaker Heart Surgery Blood Disease Anemia	Chest Pain Shortness of Breath Swelling of Feet/Ankles/Hands Fainting or Dizziness Stroke Diabetes Excessive Thirst Artificial Joints/Hips Kidney Trouble Ulcers Allergies	Hay Fever Sinus Trouble Emphysema Frequent Cough Lung Disease Tuberculosis Liver Disease Hepatitis A (infec.) Hepatitis B (serum) Yellow Jaundice Recent Weight Loss	Parathyroid Disease X-ray or Cobalt Tmt. Chemotherapy/Radiation Arthritis/Gout Rheumatism Pain in Jaw Joints Cortisone Medicine Glaucoma Epilepsy or Seizures Nervousness Alzheimer's Disease	Psychiatric Care Drug Addiction Blood Transfusion Hemophilia AIDS (HIV) Venereal Disease Cold Sores Fever Blisters Herpes Bruise Easily Sickle Cell Anemia			
Do you smoke?	u illnone not airclad ab	0402		YES NO YES NO			
Are there any predisposing	ther serious illness not circled about a factors in your health history the	at would make you susc	ceptible to HIV Aids Virus?				
				YES NO			
Women-Please check:*	doctor privately about any problem Pregnant/trying to get pregna	ant ONursing OTa	king Oral Contraceptives Date				
PATIENT SIGNAT	URE (PARENT OR GUARDIAN)						
Reviewed by: Doctor	Date	e	B.P				
MEDICAL UPDATES:							
	CAL HISTORY dated	and c	onfirm that it adequately s	tates past and present conditions			
				REVIEWED BY			
DATE EXCEP	PTIONS	ATIENT'S SIGNATURE	B.P.	I L VICTICO DI			
	NI		DR				
	None -		DR				
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