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Patient Update

Patient Personal Information

Name: _____
Last *First* *MI*

Preferred Name:_____ Social Security #: _____

Date of Birth: _____ Gender: ☐ M ☐ F ☐ _____

Marital Status: ☐ Single ☐ Married

Preferred Contact Method(s): ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Patient Address & Contact Information

Address Line 1: _____ Address Line 2:_____

City: _____State:_____ Zip:_____ Home Phone:_____

Cell Phone: _____ Work Phone: _____Email: _____

Emergency Contact Information

Emergency Contact 1: _____ Phone:_____ Relationship:_____

Responsible Party Information

If the person responsible for this patient's account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the next section

Name Of Responsible Party: _____ Date Of Birth: _____

Relationship To Patient: _____ Social Security #: _____

Contact Phone: _____ Address: _____

City: _____ State:_____ Zip:_____ Employer:_____

To the best of my knowledge, all the information provided above is true.

Patient Signature: _____Date: _____

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Patient Health History Update

Answers to the following questions are for our records only and will be considered confidential.

Name: _____
Last *First* *MI*

Preferred Name:_____ Date of Birth:_____

Name Of Medical Doctor: _____ Date Of Last Physical Exam: _____

List all medications you are currently taking: _____

_____

_____

Are you allergic to any of the following? *(Check all that apply)*

- ☐ Local Anesthesia
- ☐ NSAIDs *(Ibuprofen, Naproxen, Aspirin)*
- ☐ Codeine
- ☐ Opioids *(Percocet/Oxycodone, Vicodin/Hydrocodone, Morphine)*
- ☐ Metals
- ☐ Other: _____
- ☐ Iodine
- ☐ Latex
- ☐ Penicillin, Amoxicillin, etc.
- ☐ Sulfa
- ☐ Barbiturates

Describe your allergic reaction(s): _____

_____

Do you have any of the following medical conditions? *(Check all that apply)*

Cancer: ☐ Y ☐ N If yes, what type?_____

Chemotherapy: ☐ Y ☐ N If yes, when?_____

Radiation Therapy: ☐ Y ☐ N If yes, how many rounds?_____

Cardiovascular

- ☐ Angina (Chest Pain)
- ☐ *Artificial Heart Valve
- ☐ *Heart Murmur
- ☐ Heart Trouble
- ☐ *Congenital Heart Problems
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Scarlet Fever
- ☐ *Rheumatic Fever
- ☐ Stroke
- ☐ *Infective Endocarditis

Respiratory

- ☐ Asthma
- ☐ Emphysema
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Tuberculous
- ☐ Shortness of Breath
- ☐ COPD
- ☐ Persistent Cough

Endocrinology

- ☐ Kidney Disease
- ☐ Liver disease
- ☐ Diabetes
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Thyroid Disease

Hematologic/Lymphatic

- ☐ Anemia
- ☐ Bruise Easily
- ☐ Excessive Bleeding
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Blood Disorders

Viral Infections

- ☐ AIDS
- ☐ HIV Positive
- ☐ HPV
- ☐ Herpes
- ☐ Cold Sores
- ☐ MRSA

Neurological

- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Drug/Alcohol Addiction
- ☐ Fainting
- ☐ Seizures
- ☐ Psychiatric Treatment
- ☐ Migraines/Headaches

Musculoskeletal

- ☐ Arthritis
- ☐ *Artificial Joints
- ☐ Jaw Joint Pain
- ☐ Rheumatoid Arthritis

Gastrointestinal

- ☐ Ulcers (Stomach)
- ☐ Gastrointestinal Disease

Other

- ☐ Intellectual Disability
- ☐ * Any type of transplant
- ☐ *Steroid Treatment
- ☐ Use of Tobacco Products
- ☐ Birth Defects
- ☐ Hives of Skin Rash
- ☐ Glaucoma
- ☐ Hay Fever

Additional Medical Information

Have you had Heart Surgery? ☐ Y ☐ N Have you ever been hospitalized? ☐ Y ☐ N

Have you had a transplant operation that has depressed your immune system? ☐ Y ☐ N

Have you ever had any excessive bleeding requiring special treatment? ☐ Y ☐ N

If you use tobacco, what kind and how often/much? _____

If you have had a heart attack, how often do you see a cardiologist? _____

Do you have diabetes? ☐ Y ☐ N If yes, which type? ☐ Type 1 ☐ Type 2

When was your last A1C? _____

What is your Blood Glucose Range? _____ How often do you check it? _____

If you have Hepatitis C, has it been treated? ☐ Y ☐ N

If yes, when did you contract it? _____ When was it treated? _____

If you have sleep apnea, do you use a CPAP machine? ☐ Y ☐ N

Women Only

Are you pregnant? ☐ Y ☐ N If yes, when is the due date? _____

Are you taking oral contraceptives? ☐ Y ☐ N Is there a possibility of pregnancy? ☐ Y ☐ N

Are you currently nursing or breast feeding? ☐ Y ☐ N

Do you have any disease/problems not listed above that we should be aware of? ☐ Y ☐ N If yes, please describe:_____

Patient Signature: _____ Date:_____

Doctor Signature: _____ Date:_____

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Authorization To Release Information

Last Name: _____ First Name: _____ D.O.B: _____

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and the primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide information for ALL individuals you want us to be able to speak with.

Spouses are NOT automatically included; their names must be explicitly stated below.

You may opt out by checking the "DO NOT Release Information" box below.

Who can information be released to?	**What type of information that can be released?**
Full Name: _____	Appointments ☐
Relationship:_____	Financial Information ☐
Phone number:_____	Dental Treatment ☐
	Insurance ☐
	Other: _____

Full Name: _____	Appointments ☐
Relationship:_____	Financial Information ☐
Phone number:_____	Dental Treatment ☐
	Insurance ☐
	Other: _____

☐ DO NOT Release Information

I hereby authorize the above person(s) to have access to information covered under the Notice of Privacy Practices regarding myself.

Signature:_____ Date:_____

VELscope Oral Cancer Screening Consent Form

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Risk Factors of Oral Cancer that are controllable and un-controllable would be tobacco use, excessive alcohol consumption, using both tobacco and alcohol, excessive unprotected sun exposure, HPV viral infection, race, ethnicity and economics, high risk of cancer recurrence, gender and age.

Signs & Symptoms

Early Indicators are red and/or white discoloration of the soft tissues of the mouth, any sore that does not heal within 14 days, and hoarseness which last for a prolonged period.
Advanced Indicators would be sensation that something is stuck in your throat, numbness in the oral region, difficulty in moving the jaw or tongue, difficulty in swallowing, ear pain that occurs on one side only, being sore under a denture that won't heal, even after adjustment of the denture, or a lump or thickening which develops in the mouth or on the neck.

Oral Cancer Statistics

Each year in the US alone, approximately 34,000 individuals are newly diagnosed with oral cancer. The death rate from oral cancer is very high; about half those diagnosed will not survive more than 5 years. With early detection, survival rates are high, and side effects from treatment are at the lowest.

Get it early. Get it All-VELscope

Our practice believes in early detection of oral cancer. We can now offer you a state-of-the-art cancer exam called the VELscope Oral Cancer Screening System. As always we will continue to provide conventional oral screening exams, however now we are able to do even more!
About the VELscope Exam:

- The exam takes approximately 3-5 minutes
- The exam is comfortable and pain-free
- Completely safe to perform

_____

Patient Name Patient Signature Date

The VELscope peace-of-mind evaluation is available to you for $15.00.

_____ I accept Velscope evaluation

_____ I have read the above information with regards to the potential knowledge available through the VELscope evaluation. At this time I am choosing to decline this form of oral cancer screening.