Name_____ **Patient Coordinator**_____

Date_____ **Date of Birth**_____

Medical Alerts:
Y N
☐☐ **Allergy-Aspirin**
☐☐ **Allergy-Cephalosporins**
☐☐ **Allergy-Clindamycin**
☐☐ **Allergy-Codeine**
☐☐ **Allergy-Erythromycin**
☐☐ **Allergy-Latex**
☐☐ **Allergy-Local Anesthetics**
☐☐ **Allergy-Nitrous Oxide**
☐☐ **Allergy-Penicillin**
☐☐ **Allergies-Other or Medications**_____
☐☐ **Anaphylaxis**
☐☐ **Artificial Joints**
☐☐ **Asthma**
☐☐ **Blood Thinners**
☐☐ **Cancer Treatment**
☐☐ **Diabetes**
☐☐ **Diabetes (insulin dependent)**
☐☐ **Drug / Alcohol Addiction**
☐☐ **Epilepsy / Seizures**
☐☐ **Glaucoma**
☐☐ **Heart-Mitral Valve Prolapse**
☐☐ **Heart Problems Have you ever taken Fen-Phen / Redux?** ____
☐☐ **Heart Murmur**
☐☐ **Heart Valve Replacement**
☐☐ **Hemophilia**
☐☐ **Hepatitis B**
☐☐ **Hepatitis C**
☐☐ **High Blood Pressure**
☐☐ **HIV Positive / AIDS / Venereal disease**
☐☐ **Multiple Sclerosis**
☐☐ **Premed for dental appt**
☐☐ **Pacemaker**
☐☐ **Psychiatric Care**
☐☐ **Radiation Treatment**
☐☐ **Stroke**
☐☐ **Ulcer / Colitis**
☐☐ **Other** _____

List any medications/herbs/vitamins you are currently taking?

_____

_____

Do you have a family history of Heart Disease, Stroke, Diabetes, or Gum Disease? ***(please circle)***

Emergency Information:

Contact / Relationship _____

Phone number _____

Physician / Practice name _____

Phone number _____

Family Information:

Is there anyone else in your family that we can help with dental care? _____
_____

Referral Information:

Whom may we thank for referring you to our office? _____

Dental History:

Previous Dentist_____

Reason for leaving_____

Last Dental Exam & Xrays_____

Do you have any problems with your gums? Swelling or bleeding? _____

Do you have any fears about having dental treatment? _____

Would you be interested in being sedated for your treatment? _____

Are you happy with your smile? _____

Do you smoke or use smokeless tobacco?_____ **How Often?**_____

Patient Acknowledgement of Privacy Policy (HIPAA)

I, _____, acknowledge that I have received or reviewed the Office Privacy Policy Notice for Rocky View Dental Care, P.C.

Patient/Legal Guardian Signature_____

Should you choose to decline to sign the acknowledgement, we are required to indicate your reason(s) for refusal.

Compliance Officer_____ Date _____

Consent For Treatment

The Undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnoses of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between the insurance carrier, and me and not between the insurance and the Doctor, and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance carrier will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that when appropriate, credit reports may be obtained.

Patient/Legal Guardian Signature_____

Date_____ Dentist Signature_____

Patient Acknowledgement of Medical Information

I certify that everything stated regarding my health and dental history is correct to the best of my knowledge.
Patient/Legal Guardian
Signature_____Date_____

Rocky View Dental Care
Velscope Oral Cancer Screening Informed Consent

We know that oral cancer claims one life every hour in the US – more than the number of lives lost to skin cancer, cervical cancer or Hodgkin's disease, and it is of great concern to Dr. Wostrel.

Oral Cancer is one of the most curable diseases when caught early. This practice has incorporated the Velscope Oral Cancer Screening technology into the standard of care of the practice.

Velscope technology uses a wavelength of light which causes normal tissue to fluoresce green. Diseased tissue lacks this fluorescence. This allows us to see the diseased area before it is visible to the naked eye. It is a simple, painless and non-invasive technology that improves the Doctor's ability to visualize, mark, evaluate and monitor suspicious areas at their earliest stages, before they can progress to something far more serious, and potentially life-threatening.

Risk factors and Screening Recommendations:

- The incidence of oral cancer in young adults is increasing
- 50% of all newly diagnosed oral cancers are in individuals who do not have the historic risk factors of tobacco and alcohol usage.
- It is believed that the increase in oral cancers is due to HPV (human papilloma virus) as the majority of these tumors have the virus present in the tissue.
- The good news is that these cancers can be discovered and treated early with good results.
- The Oral Cancer Foundation now recommends an annual screening for anyone old enough to engage in sexual behaviors in order to catch the disease at its earliest possible stages.

The cost for this screening is $30.00; and we recommend that this be done once per year. Many insurance companies are starting to cover this procedure.

Please make a choice:

I _____ would like this screening.
Patient Name

I _____ do not want this screening at this time.
Patient Name

_____
Date

Missed Appointment Policy

We want to thank you for choosing us as your dental health provider. We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of 48 hours in advance if you are unable to do so.

Our missed appointment policy enables us to better utilize available appointment time for all of our patients who are in need of dental treatment. Furthermore, this enables us to keep your cost of dental care down. The following is our office policy.

- A missed appointment is when you fail to show up for an appointment without a phone call, or cancel without at least 48 hour notice.
- One missed appointment - You will receive a letter informing you of the missed appointment and will be offered to reschedule.
- Two missed appointments within a 12 month period – You will receive a letter informing you of the two missed appointments and you may be charged a $75.00 fee.
- Three missed appointments within a 12 month period – You will receive a letter informing you of the three missed appointments and you may be dismissed as a patient from the practice.

I have read and understand the above mentioned policy.

Patient name: _____

Patient Signature: _____

Date: _____