

Date _____

Last _____ First _____ Middle _____

Street _____ Apartment # _____ City _____ State _____ Zip Code _____

Sex M F

Widowed Separated Divorced

Number _____

Time _____ Retired (What Year Retired _____)

Street _____
State _____ Zip Code _____

Spouse Wk # _____

Spouse's SS# _____

for another person, what is your

Name _____ Relationship _____
of School/College _____

Emergency _____
(old) Name _____ Phone # _____

able for Account _____

Employer _____

Dr Lisc# _____

Work Phone _____

City _____ State _____ Zip _____
practice? yes no

bring you to our office?

Phone Numbers

Home () _____ Work () _____

E-Mail address _____

Mobile () _____ Pager () _____

Home Fax () _____ Work Fax () _____

Any Additional Numbers you may be reached at, including any out of town phone numbers: () _____ () _____

Insurance

Policy Holder _____ Relation to Patient _____

Date of Birth _____ Soc Sec # _____

Policy Holder Employer _____ Phone # _____

Insurance Co. _____ Ins Co. Phone # _____

Subscriber # _____ Group # _____

Is patient covered by additional dental insurance? yes no

Policy Holder _____ Relation to Patient _____

Date of Birth _____ Soc Sec # _____

Policy Holder Employer _____ Phone # _____

Ins Co. _____ Ins Co. Phone # _____

Subscriber # _____ Group # _____

Dental History

Reason for today's visit _____

Former Dentist _____ City/State _____

Date of last dental visit _____ Date of last xrays _____

Check if you have or have had any of the following:

Bad Breath Sensitivity to hot/cold Sensitivity to sweets

Bleeding Gums Tender Gums Sensitivity to biting

TMJ (popping,clicking or painful joints) Broken Fillings

Periodontal disease or treatment Dry Mouth

Clenching/Grinding of teeth Food collection

How often do you brush your teeth _____ floss _____

Do you wear dentures or partial? _____ Do you gag easily? _____

Have you had orthodontics? _____ root canals? _____ extractions? _____

Are you happy with your smile? _____ Would you like whiter teeth? _____

Medical History

Physician's Name _____ Date of last visit _____

Physician's Address _____ Phone# _____
(Street and City)

Have you had any serious illnesses or operations? yes no

Describe _____

Check if you have had any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting / Dizziness | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Nervous Condition |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Headaches | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Bleed easily | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis (When and Which type _____) | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Condition |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Jaundice | |
| <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Emphysema | | |
| <input type="checkbox"/> Epilepsy | | |
| <input type="checkbox"/> Any other conditions not listed above (specify) _____ | | |

Medications-List all you are taking _____

Do you smoke? _____

If so, how much? _____

Allergies-Check if you are allergic to:

- | | | |
|--|----------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex | <input type="checkbox"/> Metals |
| <input type="checkbox"/> Antibiotics (specify) _____ | | |
| <input type="checkbox"/> Other (specify) _____ | | |

Women-Are you pregnant? nursing? on birth control?

I have read and answered all the questions on this form to the best of my knowledge.

X _____
Signature Date

Optional Medical Insurance Information

Insurance Company: _____

Name of Policy Holder: _____

Policy Holder Date of Birth: _____

Relation to Policy Holder: _____

Contract #: _____

Group#: _____

(to be kept on file for your convenience)

Main Pharmacy (ie. CVS, Meijer, etc.)

Name: _____

Street Name and City: _____

Phone: _____

Additional Pharmacy

Name: _____

Street Name and City: _____

Phone: _____

Oral Screening Consent Form

Complete each time the examination is performed and place in the patient's file

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 16/18) plays a role in more than 20% of oral cancer cases.* Oral cancer risk by patient profile is as follows:

Increased risk: *patients ages 18-39*

-sexually active patients (HPV 16/18)

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*

We have recently incorporated ViziLite® Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite Plus is a simple and painless examination that gives the best chance to find any oral abnormalities at the 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 ViziLite Plus exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is _____.

No. I would prefer not to have the ViziLite Plus exam at this time.

Print name: _____

Signature: _____ Date: _____

VLP004 - 2/06

* J Natl Cancer Inst. 2003 Dec 3;95(23):1772-83.

Marc R. Kamp

Bloomfield Family Dental

2550 Telegraph Road, Suite 104

Bloomfield Hills, MI 48302

Patient Acknowledgment and Consent Form

Existing Effective April 14th, 2003 the new federal law known as the health insurance portability and accountability act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of the privacy of your information with we have collected and will collect in the future. To comply with one of HIPAA's requirements, we are giving you a copy of our notices privacy practices. This notice of privacy contains the information that HIPAA required us to disclose regarding our privacy practices. Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosure connection with: a defense to claim challenging our professional competence; a review entity's functions; a claim for payment of fees; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation. From time to time it may be necessary for us to make disclosure of your information in connection with your treatment, for example we may make a referral to or consult with another dentist or health care information in connection with providing or coordination of your treatment.

Patient Acknowledgment

Please sign this form below under the heading "acknowledgment" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have received a copy of the privacy practices

_____ X _____ X _____

Patient Signature

Patient Name (Please Print)

_____ X _____

Date

Patient Consent

Please sign this form below under the heading "consent" to our disclosures of your information that we deem necessary in order to provide you with proper treatment. I consent to your information which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above

_____ X _____ X _____

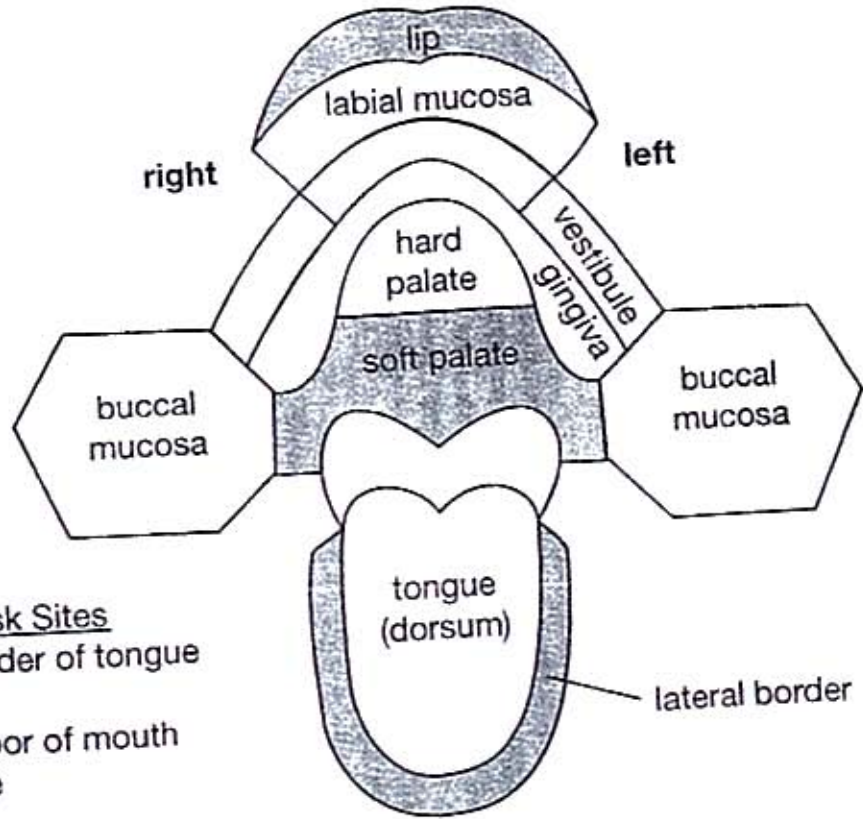
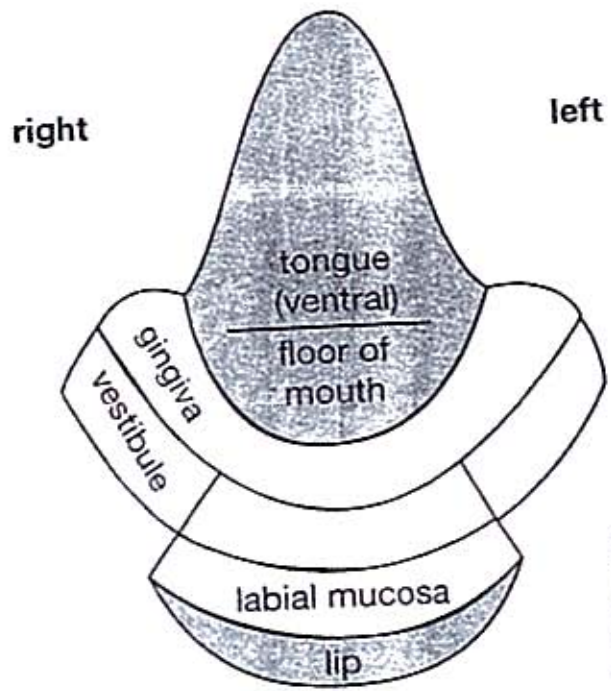
Patient Signature

Patient Name (Please Print)

_____ X _____

Date

Patient _____ ID _____
 Clinician _____ Date _____



Highest Risk Sites
 Lateral border of tongue
 Lip
 Anterior floor of mouth
 Soft palate