International Center for Advanced Dentistry

www.greatestsmile.com
2900 N Military Trail | Suite 175 • Boca Raton, FL 33431
info@greatestsmile.com
(561)922-0052

Name

____

____

Medical History Update

Have there been any changes to your health since your last visit? *

☐ Yes ☐ No

If your answer was NO please sign and date Form.
I your answer was YES please list health changes below.

List Health Changes Here.

____

____

Patient please sign below.

Signature ______________________________ **Date** __________

Provider please sign below.

Signature ______________________________ **Date** __________

Response Date: __________

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We will be offering you a flouride treatment at each of your Re-care appointments. The fee for this is $25.

The American dental association highly recommends flouride treatments for all patients regardless of age. It is especially important for adults for the following reasons:

1. Prevents cavities.
2. Strengthens enamel surfaces making teeth more resistant to cavities.
3. Helps to decrease tooth sensitivity.
4. Strenghtens root surfaces which are extremely vulnerable to decay as we age. Root surfaces do not have enamel to protect them so this is highly important.

I accept and consent to a flouride treatment at this visit.

○ YES ○ NO

Please sign below.

Signature ______________________ **Date** __________

Response Date: __________

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Name

Oral Abnormality Screening Consent Form

We are very concerned about the high incidence of oral cancer and recommend advanced screenings for EVERY patient. Even if you are a non-smoker or non-drinker you are still at risk of developing oral cancer.

Traditionally dentists and hygienists have done oral cancer screenings with the naked eye. Unfortunately most oral cancers are not visible with the naked eye until they are in the advanced stages.
We now have an advanced technology called Velscope. This will help us pinpoint and identify suspicious tissue at earlier stages before they become life threatening.

Velscope examinations are quick and painless!

I consent to having a Velscope examination. I understand I will be responsible for a fee of $25 for this screening at my visit. * ◯ Yes ◯ No

Please sign Below.

Signature ______________________ **Date** ________

Response Date: ________

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Credit Card Authorization Form

Patient Name: ______________________ * ______________________ * ___ ______________________
Last First MI Preferred Name

Address: ______________________ * ______________________
Address 1 Address 2

______________________ * _______ * _____-____ *
City State Zip Code

Credit Card Number
NO SPACES PLEASE * __________

Card Identification Number * __________

Expiration Date * __________

All Information will be kept Confidential.

This credit card is required to reserve your exclusively scheduled time with our doctors and hygienists.

Please Sign and Date

Signature ______________________________________ **Date** __________