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Oral Abnormality Screening Consent Form

We are very concerned about oral cancer and conduct screening examinations on every patient. The incidence of Oral Cancer continues to rise in the USA. The American Cancer Society indicates that since 2010 there has been an alarming 11% increase in this deadly disease. **Alarmingly, 25% of the new oral cancer cases are people that do not have any of the traditional life style risk factors, such as age, tobacco and alcohol use.**

Traditionally, our dentist and hygienists have done oral cancer screening with the naked eye, but recently a new technology, the VELscope has received FDA approval. **The VELscope (for Visually Enhanced Lesion scope) will help us pinpoint and identify suspicious tissue at earlier stages before they become life threatening concerns.**

VELscope, similar to the early detection procedures like colonoscopy, mammography, PAP smear and PSA exam, is a painless, safe, non-invasive blue light that is shined into the patient's mouth. The images are viewed through the back of the VELscope hand piece and assists the hygienist or dentist find tissue abnormalities at an earlier stage. Before the exam, the room may be darkened and much like "desert storm night vision technology" the clinician can see changes in tissue that may not be visible to the naked eye. These detected changes can range from something minor to something of greater concern that may require further examination and follow up.

The VELscope testing is an addition to our traditional visual oral cancer screening and will add only a few minutes to the entire exam. The normal fee for this procedure is \$65, however, **the Doctor feels so strongly that every patient has this examination at least once a year our charge for the examination is only \$25.** The VELscope exam may or may not be covered by dental insurances. **As part of our standard of care and because we care about you, we strongly recommend that you choose this additional screening procedure.**

Please sign the area below to accept the financial responsibility for this procedure.

Thank you for your kind consideration.

- YES, I consent to the VELscope examination.**
- NO, I decline the offer by this office to perform the VELscope examination.**

PRINT NAME _____

SIGNATURE _____

DATE _____