

AGAPE D E N T A L

Please review the Oral Cancer Consent Form, and sign under the decision you choose.

Most insurance companies have not been covering this procedure yet, but it will still be submitted to your insurance with any other procedures performed today. Once insurance reviews the claim then a statement will be sent to you by mail for the balance. The fee for this procedure is \$25.00.

Thank You.

Dr. Sipes' Office



CONSENT FORM ORAL CANCER SCREENING

COMPLETE FOR EACH PATIENT AND PLACE IN RECORDS OF PATIENT.

In our practice, as your healthcare provider, we seek to provide you access to the newest and most effective scientific screening and treatment. In 2009 the StarDental® Identafi® system was introduced. This multispectral medical device greatly enhances our ability to find early signs of cancer and dysplasia in the mouth. Historically our practice has used white light in examination for oral cancer. The use of narrow band violet light and green-amber reflected light helps us detect in the oral tissue various problems including cancer lesions and dysplasia.

Early detection of oral cancer is important to being able to provide early treatment and avoidance of the problems which arise from late stage detection of oral cancer. We encourage you to discuss with us your questions related to detection of oral cancer.

The Oral Cancer Foundation advises that 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. Recently scientists have established a connection between HPV viral infection in the mouth and the occurrence of oral cancer.

Yes. I request that the clinician perform the StarDental Identafi examination. I accept financial responsibility for this examination.

Print name: _____

Signature: _____ Date: _____

No. I would prefer not to have this examination at this time.

Print name: _____

Signature: _____ Date: _____

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 HENRY SCHEIN®
DENTAL

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