RIO SALADO COLLEGE
A MARICOPA COMMUNITY COLLEGE

DENTAL CLINIC

Blue or Black Pen Only

Please Write Legibly

Chart #:_____

Treatment Alert ☐

PERSONAL INFORMATION

Date: _____

Name: _____ Address: _____
Last First Middle Number, Street

City: _____ State: _____ Zip Code: _____ Home Phone: _____ Mobile Phone: _____

Date of Birth: _____ Sex: _____ Height: _____ Weight: _____ Single: _____ Married: _____

Email: _____ Name of Spouse: _____

In case of emergency call: _____ Phone: _____

For Minors: Parent/Guardian Name: _____ DOB: _____

FAMILY DENTIST: _____ Phone: _____

Address: _____ Date of last dental exam: _____

PRIMARY CARE PHYSICIAN: _____ Phone: _____

Address: _____ Date of last physical exam: _____

OTHER PHYSICIANS: _____

PART I - MEDICAL HISTORY

Our purpose is to obtain pertinent medical history essential to complete diagnosis and treatment planning. All patient information is kept confidential, and will not be disclosed without the patient's written permission.

A. How would you rate your health? ☐ Good ☐ Fair ☐ Poor

B. Are you under the care of a physician? ☐ Yes ☐ No

If yes, please explain what you are being treated for: _____

C. Have there been any changes in your health in the past year? ☐ Yes ☐ No

If yes, please describe: _____

D. Please check Yes or No if you have or have had any of the following (mark each box individually):

	Yes	No		Yes	No		Yes	No	
1.	☐	☐	Congenital Heart Disease	☐	☐	Lung Disease	☐	☐	Kidney Disease
2.	☐	☐	Heart Attack - Date: _____	☐	☐	Tuberculosis (TB) Date: _____	☐	☐	Stomach/Intestinal Disease/Ulcer
3.	☐	☐	Heart Murmur	☐	☐	Shortness of Breath	☐	☐	Seizures/Convulsions
4.	☐	☐	Rheumatic Fever	☐	☐	Frequent/Long-term Cough	☐	☐	Epilepsy
5.	☐	☐	Mitral Valve Prolapse	☐	☐	Cough Up Blood	☐	☐	Nervous Problems
6.	☐	☐	Irregular Heart Beat	☐	☐	Emphysema	☐	☐	Psychiatric Treatment
7.	☐	☐	Angina/Chest Pain	☐	☐	Tumor or Growth	☐	☐	Drug/Alcohol Treatment
8.	☐	☐	Heart Surgery - Date: _____	☐	☐	Cancer-Type: _____	☐	☐	Steroid Treatment
9.	☐	☐	Artificial Heart Valve	☐	☐	Radiation Therapy	☐	☐	Rheumatism
10.	☐	☐	Heart Pacemaker - Date: _____	☐	☐	Chemotherapy	☐	☐	Arthritis
11.	☐	☐	High Blood Pressure	☐	☐	Immunosuppressive Disorders	☐	☐	Artificial Joint/Prosthetic Replacement
12.	☐	☐	Low Blood Pressure	☐	☐	AIDS	☐	☐	Pain in Joints
13.	☐	☐	Stroke - Date: _____	☐	☐	HIV Positive	☐	☐	Bleeding/Bruises Easily
14.	☐	☐	Anemia	☐	☐	Venereal Disease	☐	☐	Fainting/Dizziness
15.	☐	☐	Blood Disease	☐	☐	Fever Blisters/Cold Sores	☐	☐	Recent Weight Loss/Gain
16.	☐	☐	Blood Transfusion – Date: _____	☐	☐	Lupus	☐	☐	Loss of Appetite
17.	☐	☐	Hepatitis A-B-C, Other: _____	☐	☐	Autoimmune Disease	☐	☐	Hives/Rash
18.	☐	☐	Liver Disease/Jaundice	☐	☐	Organ Transplant	☐	☐	Hearing difficulty
19.	☐	☐	History of Domestic Violence	☐	☐	Diabetes – Type: I , II	☐	☐	Vision Changes
20.	☐	☐	Asthma	☐	☐	Thyroid Disease	☐	☐	Sinus Problems

Comments: _____

E. Do you have any disease, condition or problem not listed? ☐ Yes ☐ No

If yes, please describe: _____

_____

F. List all hospitalizations/operations you have had in the past 5 years: _____

_____

_____

G. Have you ever experienced an unusual or allergic reaction to any of the following:

☐ Latex ☐ Aspirin ☐ Local Anesthetic

☐ Penicillin ☐ Codeine ☐ Other: _____

_____

_____

H. Please list any medications you have taken within the past six months (include prescriptions, over-the-counter, birth control, diet drugs, nutritional / herbal supplements, etc.): _____

_____

_____

I. Please list any recreational drugs you have used within the last six months (confidential): _____

_____

J. Please list any tobacco products you may have used within the last six months:

Types (cigar, cigarette, chew, etc.): _____

Amount (packs/day, pipefulls, etc.): _____ For how long (months, years): _____

K. How many alcoholic drinks do you have each week? _____

L. Do you wear contact lenses? ☐ Yes ☐ No

M. Have you had anything to eat or drink in the past four hours? ☐ Yes ☐ No

N. WOMEN ONLY: (Check all that apply)

☐ Pregnant # of months: _____ ☐ Trying to get Pregnant ☐ Nursing

[FACULTY/STUDENT USE:]

COMMENTS:

PART II - DENTAL HISTORY

A. How important to you is the way your teeth look?

☐ Very important
☐ Somewhat important
☐ Unimportant

B. Generally, how have you felt about your previous dental appointments?

☐ Very anxious and afraid ☐ Don't care one way or the other
☐ Somewhat anxious and afraid ☐ Look forward to it

C. Have you had bleeding problems following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

D. In the past two years, have you experienced any of the following symptoms?
(If yes, please check all that apply:)

☐ Sensitive teeth ☐ Sore jaw ☐ Toothache ☐ Sore gums
☐ Bleeding gums ☐ Difficulty chewing ☐ Filling fell out ☐ Dry mouth
☐ Bad breath ☐ Burning sensation ☐ Abscess ☐ Swollen face
☐ Swelling inside mouth ☐ Tartar buildup ☐ Yellowing teeth ☐ Difficulty swallowing

Comments: _____

_____

E. When you look inside your mouth, do you know how to look for?

	Yes	No
Tooth Decay	☐	☐
Oral Cancer	☐	☐
Gum Disease	☐	☐

F. About how many times in the last two years have you seen a dental professional for each of the following:

_____ Checkups and cleanings

_____ Radiographs – Type: _____ How long ago: _____.

_____ Dental emergencies

_____ Other dental treatment such as fillings, gum treatment, crown (caps), bridges, dentures

G. Do you clench or grind your teeth in the daytime or at night?

☐ Yes ☐ No

If yes, do you wear a bite guard? _____ For how long? _____

H. Are you concerned about the appearance of your teeth? (If yes, please check all that apply:)

☐ Yellowing/graying teeth ☐ Stains ☐ Crowded, crooked ☐ Spacing between teeth

Other _____

I. Check any of the following you regularly use at home:

☐ Soft toothbrush	☐ Dental floss	☐ Floss threader	☐ Powered interdental cleaner
☐ Hard toothbrush	☐ Special brush	☐ Toothpick	☐ Powered brush
☐ Medium toothbrush	☐ Fluoride toothpaste	☐ Fluoride rinse or gel	☐ Other _____
☐ Oral irrigator	☐ Rubber tip	☐ Mouth rinse	
☐ Denture adhesive	☐ Dental cleanser	☐ Whitening product	

J. Check the type of toothpaste you use:

☐ Fluoride	☐ Tartar control	☐ Gum benefit	☐ Whitening	☐ None
☐ Sensitivity protection	☐ Baking soda	☐ Peroxide	☐ Multiple benefit	

K. About how many times each day/week do you brush and floss?

1 brush about _____ times per day OR _____ per week

1 floss about _____ times per day OR _____ per week

L. About how long does it take you to clean your teeth and gums each time?

Brushing _____ (time) Flossing _____ (time)

M. Do you find it difficult to clean your teeth due to your job/profession or other reasons?

☐ Yes ☐ No

N. Do any of the following conditions make it difficult for you to clean your teeth? (If yes, please check all that apply:)

☐ Hold a toothbrush ☐ Use dental floss ☐ Brush/floss for any length of time ☐ Don't see well

I verify the information I have provided is accurate and I consent to have a Rio Salado College dental hygiene student perform any usual dental hygiene procedures on myself, or my child that are authorized by the supervising dentist unless indicated otherwise. (I will not hold the dentist, students or staff responsible for any errors or omissions that I may have made in the completion of this form.) I understand that if any change occurs in my health, I am to report it to the dental hygiene clinic as soon as possible during my course of treatment.

Authorization and Release: I authorize Rio Salado College to release any information including records of any treatment or examination rendered to me or my child during the period of such Dental Hygiene care to myself or health practitioners.

_____ _____

Signature of Patient (Parent or Guardian of Minors) Date

_____ _____

Signature of Dentist Date

_____ _____

Signature of Student Date

This form must be updated every two years.

Informed Consent to Treatment – Dental Hygiene

Welcome to the Rio Salado College Dental Hygiene Clinic! We are pleased that you are interested in bettering your dental health, and we wish to provide you thorough treatment. The clinic policies are outlined for your review. Our staff will be happy to further explain any policies and are open to any comments you may have.

Clinic Policies

Appointments: This is an educational facility; therefore appointments are 4 hours in length. All services are provided by dental hygiene students under the guidance of licensed dentists and dental hygienists and patients may expect to have multiple appointments to complete treatment.

As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Appointment changes must be made at least 24 hours prior to your appointment time, except in an emergency. A history of broken appointments may result in refusal of treatment at the Rio Salado College Dental Hygiene Clinic.

It is the patient/guardian's responsibility to notify our office if there is a change of name, residence and/or phone number.

Because Rio Salado College Dental Clinic is an educational facility, it is highly recommended that individuals who have difficulty reading or speaking English provide an interpreter at every appointment.

Minors: For children under age 18, a parent or legal guardian must complete the medical dental history, sign the Informed Consent to Treatments and authorize treatment at the initial appointment and at all future recare appointments. The parent or legal guardian must be available by phone if they are not present during the appointment.

Children in the reception room must be accompanied and supervised by an adult at ALL times.

Fees and Payment: A fee will be collected prior to treatment. Services include a complete cleaning, any x-rays needed, fluoride, other treatment deemed necessary. No refunds are given once treatment has been started. Students are required to finish treatment in a specific amount of time. If treatment is incomplete or delayed due to missed appointments or cancellations, a new treatment fee may be assessed. Changes may be made at the discretion of the program director.

Dental Insurance: Patients must submit their own dental insurance forms to their insurance company. To assist you, your dental hygiene student will provide an Insurance Code form upon request.

Radiograph/Chart Release: Patients may receive a printed, or electronic, copy of their radiographs or chart for a fee. A written release form is required. Please see front office for details. Requests may take 3 business days for processing.

Continued Care: The procedures performed at the Rio Salado College Dental Hygiene Clinic do not replace regular dental examinations by your dentist. Recare appointments may not always be available. The program advocates regular exams and other services provided by your regular dentist. If you do not have a dentist, a referral list will be made available.

Infection Control Practices: The Rio Salado College Dental Hygiene Program practices and employs current infection control policies with all aspects of patient care.

Patient Privacy: Rio Salado College adheres to strict standards for maintaining the confidentiality of patient records, including limiting access to records, ensuring the security of records including electronic information, and disposing of patient information in a secure manner.

Rio Salado College Policies:

It is the policy of Rio Salado College, a part of the Maricopa County Community College District, not to discriminate on the basis of sex, race, color, sexual orientation, national origin, religion, political belief, age, handicap, disability, or record of arrest or conviction.

Rio Salado College is a smoke-free facility.

Authorization

1. I will permit Rio Salado College faculty to photograph or videotape record all or part of any treatment given to me or my child for the advancement of dental hygiene education without financial reward to myself.
2. I authorize Rio Salado staff and its Dental Hygiene Program students working under their supervision to perform the procedures recommended for optimal dental health. These procedures will include, but not be limited to, prophylaxis, oral health instruction, x-rays, and fluoride treatments. I understand that Rio Salado College may deny me or my child treatment if I decline a particular treatment.
3. I understand that no warranty or guarantee has been made to me as to result or cure.
4. I understand that, should I need medical attention due to a medical emergency or for other reasons, I will be responsible for those medical expenses, including transport by ambulance, and that as a result receipt of dental hygiene services may be delayed.
5. I have read and understand this Informed Consent to Treatment form, and agree with all of its terms. I have had an opportunity to have all my questions answered.

PATIENT'S BILL OF RIGHTS

The patient has the right to considerate and respectful care.

The patient has the right to obtain complete current information concerning his/her diagnosis, treatment, and prognosis, in terms the patient can understand.

The patient has the right to know any treatment alternatives, risk of no treatment, and expected outcomes of various treatments.

The patient has the right to receive from his/her clinician necessary information to give informed consent prior to the start of any procedure and/or treatment, as well as the right to refuse any treatment.

The patient has the right to continuity and completion of dental treatment that meets the standards of care in the profession.

The patient has the right to every consideration of privacy and confidentiality.

The patient has the right to examine and receive an explanation of the cost of dental treatment.

Patients may be given a printed copy of this form after signing. If you would like a copy of the Initial Informed Consent and Patient's Bill of Rights please inform the Front Desk staff.

Today's Date: _____

Patient Name (Please Print): _____

Patient Signature (Parent/Guardian for Minors): _____

 CONTINUED ON OTHER SIDE