

PERSONAL INFORMATION

Date: _____

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

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

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. <input type="checkbox"/> | <input type="checkbox"/> Congenital Heart Disease | 21. <input type="checkbox"/> | <input type="checkbox"/> Lung Disease | 41. <input type="checkbox"/> | <input type="checkbox"/> Kidney Disease |
| 2. <input type="checkbox"/> | <input type="checkbox"/> Heart Attack - Date: _____ | 22. <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis (TB) Date: _____ | 42. <input type="checkbox"/> | <input type="checkbox"/> Stomach/Intestinal Disease/Ulcer |
| 3. <input type="checkbox"/> | <input type="checkbox"/> Heart Murmur | 23. <input type="checkbox"/> | <input type="checkbox"/> Shortness of Breath | 43. <input type="checkbox"/> | <input type="checkbox"/> Seizures/Convulsions |
| 4. <input type="checkbox"/> | <input type="checkbox"/> Rheumatic Fever | 24. <input type="checkbox"/> | <input type="checkbox"/> Frequent/Long-term Cough | 44. <input type="checkbox"/> | <input type="checkbox"/> Epilepsy |
| 5. <input type="checkbox"/> | <input type="checkbox"/> Mitral Valve Prolapse | 25. <input type="checkbox"/> | <input type="checkbox"/> Cough Up Blood | 45. <input type="checkbox"/> | <input type="checkbox"/> Nervous Problems |
| 6. <input type="checkbox"/> | <input type="checkbox"/> Irregular Heart Beat | 26. <input type="checkbox"/> | <input type="checkbox"/> Emphysema | 46. <input type="checkbox"/> | <input type="checkbox"/> Psychiatric Treatment |
| 7. <input type="checkbox"/> | <input type="checkbox"/> Angina/Chest Pain | 27. <input type="checkbox"/> | <input type="checkbox"/> Tumor or Growth | 47. <input type="checkbox"/> | <input type="checkbox"/> Drug/Alcohol Treatment |
| 8. <input type="checkbox"/> | <input type="checkbox"/> Heart Surgery - Date: _____ | 28. <input type="checkbox"/> | <input type="checkbox"/> Cancer-Type: _____ | 48. <input type="checkbox"/> | <input type="checkbox"/> Steroid Treatment |
| 9. <input type="checkbox"/> | <input type="checkbox"/> Artificial Heart Valve | 29. <input type="checkbox"/> | <input type="checkbox"/> Radiation Therapy | 49. <input type="checkbox"/> | <input type="checkbox"/> Rheumatism |
| 10. <input type="checkbox"/> | <input type="checkbox"/> Heart Pacemaker - Date: _____ | 30. <input type="checkbox"/> | <input type="checkbox"/> Chemotherapy | 50. <input type="checkbox"/> | <input type="checkbox"/> Arthritis |
| 11. <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | 31. <input type="checkbox"/> | <input type="checkbox"/> Immunosuppressive Disorders | 51. <input type="checkbox"/> | <input type="checkbox"/> Artificial Joint/Prosthetic Replacement |
| 12. <input type="checkbox"/> | <input type="checkbox"/> Low Blood Pressure | 32. <input type="checkbox"/> | <input type="checkbox"/> AIDS | 52. <input type="checkbox"/> | <input type="checkbox"/> Pain in Joints |
| 13. <input type="checkbox"/> | <input type="checkbox"/> Stroke - Date: _____ | 33. <input type="checkbox"/> | <input type="checkbox"/> HIV Positive | 53. <input type="checkbox"/> | <input type="checkbox"/> Bleeding/Bruises Easily |
| 14. <input type="checkbox"/> | <input type="checkbox"/> Anemia | 34. <input type="checkbox"/> | <input type="checkbox"/> Venereal Disease | 54. <input type="checkbox"/> | <input type="checkbox"/> Fainting/Dizziness |
| 15. <input type="checkbox"/> | <input type="checkbox"/> Blood Disease | 35. <input type="checkbox"/> | <input type="checkbox"/> Fever Blisters/Cold Sores | 55. <input type="checkbox"/> | <input type="checkbox"/> Recent Weight Loss/Gain |
| 16. <input type="checkbox"/> | <input type="checkbox"/> Blood Transfusion - Date: _____ | 36. <input type="checkbox"/> | <input type="checkbox"/> Lupus | 56. <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite |
| 17. <input type="checkbox"/> | <input type="checkbox"/> Hepatitis A-B-C, Other: _____ | 37. <input type="checkbox"/> | <input type="checkbox"/> Autoimmune Disease | 57. <input type="checkbox"/> | <input type="checkbox"/> Hives/Rash |
| 18. <input type="checkbox"/> | <input type="checkbox"/> Liver Disease/Jaundice | 38. <input type="checkbox"/> | <input type="checkbox"/> Organ Transplant | 58. <input type="checkbox"/> | <input type="checkbox"/> Hearing difficulty |
| 19. <input type="checkbox"/> | <input type="checkbox"/> History of Domestic Violence | 39. <input type="checkbox"/> | <input type="checkbox"/> Diabetes - Type: I, II | 59. <input type="checkbox"/> | <input type="checkbox"/> Vision Changes |
| 20. <input type="checkbox"/> | <input type="checkbox"/> Asthma | 40. <input type="checkbox"/> | <input type="checkbox"/> Thyroid Disease | 60. <input type="checkbox"/> | <input type="checkbox"/> 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| Oral Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Gum Disease | <input type="checkbox"/> | <input type="checkbox"/> |

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:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Soft toothbrush | <input type="checkbox"/> Dental floss | <input type="checkbox"/> Floss threader | <input type="checkbox"/> Powered interdental cleaner |
| <input type="checkbox"/> Hard toothbrush | <input type="checkbox"/> Special brush | <input type="checkbox"/> Toothpick | <input type="checkbox"/> Powered brush |
| <input type="checkbox"/> Medium toothbrush | <input type="checkbox"/> Fluoride toothpaste | <input type="checkbox"/> Fluoride rinse or gel | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Oral irrigator | <input type="checkbox"/> Rubber tip | <input type="checkbox"/> Mouth rinse | |
| <input type="checkbox"/> Denture adhesive | <input type="checkbox"/> Dental cleanser | <input type="checkbox"/> Whitening product | |

J. Check the type of toothpaste you use:

- | | | | | |
|---|---|--------------------------------------|---|-------------------------------|
| <input type="checkbox"/> Fluoride | <input type="checkbox"/> Tartar control | <input type="checkbox"/> Gum benefit | <input type="checkbox"/> Whitening | <input type="checkbox"/> None |
| <input type="checkbox"/> Sensitivity protection | <input type="checkbox"/> Baking soda | <input type="checkbox"/> Peroxide | <input type="checkbox"/> 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 (Parent/Guardian for Minors) Signature : _____