APPENDIX CP 2

Phoenix College Dental Clinic
Important Information for Our Patients

Thank you for choosing an educational facility for your dental needs. Our Dental Assisting and Dental Hygiene Programs are accredited by the Commission on Dental Accreditation of the American Dental Association and we take pride in offering dental care that meets the highest standards of the professions. We would like to take this opportunity to explain the policies and procedures of our clinical teaching facility.

Dental Hygiene Clinic

Dental hygiene students perform cleanings, take radiographs (x-rays), administer dental anesthesia, give fluoride treatments and apply sealants. They also perform oral cancer exams, check your blood pressure, and pulse and give homecare tooth brushing instructions. The Dental Hygiene Clinic is a teaching clinic: therefore, patients receiving dental hygiene care will be participating in the teaching program. Only patients whose care is suitable for teaching purposes are eligible for treatment in the clinic. New Patients require an initial evaluation or assessment appointment to determine if they are eligible. Patients not offered dental hygiene treatment will be referred for treatment to a dentist of their choice. Some patients may initially qualify for treatment and later, after initial therapy is completed, may no longer be considered appropriate as teaching cases; in this case, services will be discontinued, and a referral will be provided. The dental hygiene faculty reserves the right to refuse or discontinue treatment. Dental hygiene treatment will be performed by a student and will be supervised faculty. Treatment received in our clinic requires ***significantly*** more time than care provided in a private dental practice.

- Most appointments are approximately three hours in length. For adults, multiple appointments are usually required.
- For children under 18 years of age, a parent or legal guardian must remain in the clinical facility during the appointment and must sign the Consent for Treatment form.
- Individuals who have difficulty reading or speaking English must provide an interpreter at every appointment.
- Scheduling maintenance visits will be the patient's responsibility.
- Patients are responsible for all personal items brought into the Phoenix College dental clinic. Phoenix College will not be responsible for any lost or misplaced personal items.

Patient's Right and Responsibilities

1. Patients of our facility will be given considerate, respectful and confidential treatment. Mutual respect from patients towards the dental clinic team members (faculty, students, dentists, and staff) is expected. **Our goal is to complete any treatment started; however, as an educational facility, we must work within certain constraints and limitation. The educational setting makes it impossible for us to consistently provide patients with long-term care.** We will be happy to give you referral information for dental procedures we cannot provide. Upon your request and consent, we will send your radiographs to the dentist of your choice for a nominal duplicating fee.

2. Our facility is closed approximately FIVE months per year (winter, spring and summer breaks, and all other observed holidays). Due to this limited schedule, we suggest and encourage you to maintain relationships with dental practitioners in the community to ensure that all your dental needs can be met.

3. You will have access to complete and current information about your condition and will be required to give your consent for treatment. You will be provided with an explanation for recommended treatment, alternatives, the option to refuse treatment, and the expected outcome of various treatments.

4. Payment is required prior to services being rendered. We will give you a receipt to send to your insurance company for reimbursed of fees. Fees are honored until the care plan is complete and/or for the duration of the academic year.

APPENDIX CP 2

Phoenix College Dental Clinic
Important Information for Our Patients

Termination of Clinician-Patient Relationship Policy

It is the policy of Phoenix College Dental Clinic to maintain a cooperative and trusting clinician-patient relationship with its patients. When such a clinician-patient relationship has not been formed or a clinician-patient relationship is no longer proceeding in a mutually productive manner, it is the policy of the dental clinic to terminate the clinician-patient relationship so that the patient can develop the type of trusting relationship with another dental clinic that is essential to successful continued care and treatment.The dental clinic is associated with an educational program, and, as such, students, faculty/staff, and patients must comply with this policy.

Sexual Harassment and Discrimination Policy

The policy of the Maricopa County Community College District (MCCCD) is to provide an educational, employment, and business environment free of sexual violence, unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct or communications constituting Sexual Harassment as prohibited by state and federal law. Discrimination under this Policy is an unequal treatment of a student based on the student's actual or perceived gender, sexual orientation, or pregnancy. This Policy prohibits Sexual Harassment and Discrimination in any college education program or activity, which means all academic, educational, extracurricular, athletic and other programs.

Sexual harassment is defined as any unwelcome verbal or physical conduct of a sexual nature that is sufficiently severe, persistent, or pervasive that it unreasonably interferes with, limits, or deprives a student of the ability to participate in or benefit from any MCCCD educational program or activity.

Refund Policy

If you choose to discontinue treatment and request a refund from Phoenix College Dental Clinic, you will be refunded:
$15.00 if radiographs were taken at any time during your dental visit(s)
$35.00 if no radiographs were taken
All Refunds will be processed back to the original form of payment through Phoenix College Cashiers Office in Hannelly Center on Phoenix College Campus. Please bring a current photo ID to Cashiers Office at 1202 W. Thomas Rd., Phoenix, AZ. 85013

How to Request a Refund

- Contact Phoenix College Dental Clinic at 602-285-7323 and request a refund OR
- Email refund request to: PC-Dental-Images@phoenixcollege.edu
- Upon receipt of a request for a refund, Phoenix College Dental Clinic will confirm all payments by check have cleared the bank (may take up to 15 business days)
  Refund of payment originated through a credit card company must be refunded to the originating credit card account (it may take up to 7 business days for the credit card company to post the payment to the cardholder's account)

Cancellation Policy

You and your appointment time are very important parts of our students' educational training. The students are required to give their scheduled patients who are late a 15-minute grace period. After this grace period, they/we may reassign the appointed time to another patient. If you fail twice to keep a scheduled appointment, we will not be able to reschedule you in our facility. Please call us 24 hours in advance if you are unable to keep ANY scheduled appointment in our facility, and we will be happy to reschedule a more convenient time for you. Our students rely on you for their clinical experience and we all appreciate the time you share with us.

Patient's Name _____ Age _____ Phone _____

Clinic Information and Consent

The purpose of today's appointment is to determine whether or not your dental hygiene treatment needs can be managed in our clinic and to assist us in scheduling your appointments. Please be advised that:

1. This dental hygiene clinic performs dental hygiene procedures primarily to provide student learning opportunities. Our services include dental prophylaxis (cleanings), digital images (x-rays), fluoride treatments, sealants, dental anesthesia and oral health education. All procedures are performed by students under the direct supervision of faculty who are licensed dental professionals.
2. Some patients will be informed at the screening appointment that Phoenix College Dental Hygiene Program will be unable to meet their needs.
3. Appointments are longer than you would experience in a private dental office. If you are unable to commit to several 3 hour appointments, then you may not be eligible for treatment in this facility.
4. Patients will be referred to their own dentist for ongoing dental evaluation. If you do not have a dentist of record, referral information will be made available. We are not a full service dental clinic and are unable to consistently provide patients with long-term dental care.

My signature below indicates that:

1. I have read and understand the above information.
2. I consent to this screening procedure which includes a limited examination of my teeth and gums.
3. I understand that if I am eligible for treatment, and I agree to proceed, then the fee for services must be paid prior to receiving those services.
4. I give my permission to allow my patient records to be used for educational purposes in this setting.

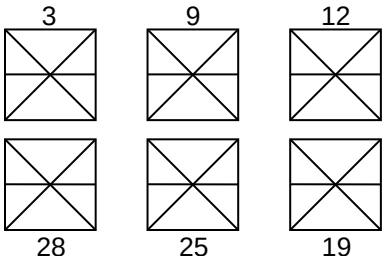
Signature _____ Date _____

SCREENING 'Assessment' 'REPORT

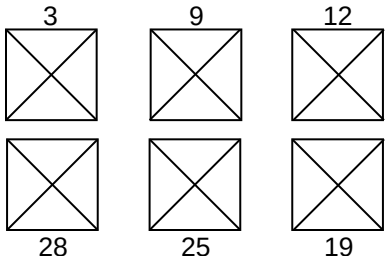
Yes No A medical consultation is necessary prior to proceeding with the screening.

Yes No A medical consultation is necessary prior to appointing the patient for dental hygiene care.

Periodontal Screening



Calculus Screening



Bleeding: None Delayed Slt Mod Heavy

Preliminary Perio. Classification: 0 I II III IV

Preliminary Calculus Class: L M H H+

Estimated # of appointments _____

Patient is ineligible _____

Treatment Considerations / Comments _____

_____

_____

Student _____ Faculty _____ Date _____

Radiography Order: ____NONE____FMS-HBW ____FMS-VBW ___ HBW 2 4 VBW 2 3 4 7 ___ PANO ___ OCC ___ PA(S) / Dr._____

ASSIGN TO STUDENT: _____#_____ **Placed on call list: _Y / N_**

MEDICAL HISTORY

Patient Name_____Date:_____
Last First Middle

Date Of Birth _____/_____/_____
Month Day Year

Name of Primary Care Physician:_____Phone: ( )_____

Other physicians caring for you: _____

Yes	No	
☐	☐	Have you **ever been** hospitalized or had a major operation? Explain_____
☐	☐	Have you **ever had** a serious injury to your head or neck? Explain_____
☐	☐	Are you taking any medications, pills or drugs? List_____
☐	☐	Are you taking any herbal supplements? List_____
☐	☐	Are you taking any vitamins? List_____
☐	☐	Have you ever taken fen-phen? _____
☐	☐	Are you allergic to any medications or substances? Check box below:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Metal ☐ Latex/Rubber ☐ Other_____

Do you now have or have you ever had any of the following? Please check the appropriate yes/no box separately for each condition.

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Disease/Defect	☐	☐	Pain in the Jaw	☐	☐	Stomach/Intestinal Disease
☐	☐	Heart Murmur	☐	☐	Cortisone Medication	☐	☐	Ulcers
☐	☐	Irregular Heart Beat	☐	☐	Swelling of Limbs	☐	☐	Recent Weight Loss
☐	☐	Angina/Chest Pain	☐	☐	Lung Disease	☐	☐	Convulsions/Seizures
☐	☐	Heart Attack	☐	☐	Breathing Problems	☐	☐	Epilepsy
☐	☐	Heart Failure	☐	☐	Shortness of Breath	☐	☐	Diabetes
☐	☐	Rheumatic Fever	☐	☐	Frequent Cough	☐	☐	Excessive Thirst
☐	☐	Mitral Valve Prolapse	☐	☐	Hay Fever	☐	☐	Hypoglycemia
☐	☐	Artificial Heart Valve	☐	☐	Sinus Trouble	☐	☐	Liver Disease
☐	☐	Heart Pacemaker	☐	☐	Asthma	☐	☐	Hepatitis-**type**_____
☐	☐	Heart Surgery	☐	☐	Emphysema	☐	☐	Yellow Jaundice
☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐	Kidney Problems
☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐	Renal Dialysis
☐	☐	Stroke	☐	☐	Fainting/Dizziness	☐	☐	Arthritis-**type**_____
☐	☐	Blood Disease	☐	☐	Cancer	☐	☐	Drug Addiction
☐	☐	Bruise Easily	☐	☐	Tumor Growth	☐	☐	Alcohol Addiction
☐	☐	Anemia	☐	☐	Radiation Treatment	☐	☐	Psychiatric Care
☐	☐	Bleed Problems	☐	☐	Chemotherapy	☐	☐	Cold Sores/Fever Blisters
☐	☐	Hemophilia	☐	☐	Artificial Joint	☐	☐	Herpes
☐	☐	Leukemia	☐	☐	AIDS	☐	☐	Nervousness
☐	☐	Allergies to Drugs	☐	☐	HIV Positive	☐	☐	Alzheimer's Disease
☐	☐	Allergies to Pollen/Dust	☐	☐	Sexually Transmitted Infection	☐	☐	Disability-**type**_____
☐	☐	Hives/Rash	☐	☐	Osteoporosis/Osteopenia	☐	☐	Other_____

Women Only – Please check the appropriate box:

☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking Oral contraceptives ☐ Menopausal

I have reviewed my Medical History and confirm that it adequately states past and present conditions.

X_____Date_____
Signature

ASA CLASSIFICATION

_____DDS/DMD_____BP_____Pulse_____Respiration_____

Date	Updates	None	Patient's Signature	BP	ASA	DDS/DMD Initials
_____	_____	☐	_____	_____	_____	_____
_____	_____	☐	_____	_____	_____	_____
_____	_____	☐	_____	_____	_____	_____
_____	_____	☐	_____	_____	_____	_____
_____	_____	☐	_____	_____	_____	_____
_____	_____	☐	_____	_____	_____	_____

(Updated 9/2013)

MEDICATIONS

Patient's Name: _____

Date	Medication & Dosage	Purpose for Medication	Oral Effects, Precautions to Dental Treatment

Patient Interview

DATE	COMMENTS

NAME _____ DATE _____

DENTAL HISTORY

☐ Yes ☐ No *Do you have dental examinations and cleanings on a routine basis?
Date of last visit_____

Generally, how have you felt about your previous dental appointments?
☐ Very anxious and afraid ☐ Somewhat anxious and afraid ☐ Don't care one way or the other ☐ Look forward to it

*Check any of the following that you have experienced in the past two years:

☐ toothache	☐ sensitive teeth	☐ stains	☐ sore jaw	☐ spacing between teeth
☐ abscess	☐ bad breath	☐ yellowing/graying teeth	☐ difficulty chewing	☐ clench, grind, brux
☐ swelling inside mouth	☐ sore gums	☐ loose teeth	☐ difficulty swallowing	☐ other_____
☐ swollen face	☐ bleeding gums	☐ dry mouth	☐ food catching between teeth	
☐ filling fell out	☐ tartar buildup	☐ burning sensation	☐ crowded/crooked teeth	

Comments_____

HOMECARE PRACTICES

Check any of the following you regularly use at home:

☐ soft toothbrush	☐ special brush	☐ oral irrigator	☐ rubber tip
☐ hard toothbrush	☐ dental floss	☐ powered interdental cleaner	☐ denture cleanser
☐ medium toothbrush	☐ floss threader	☐ fluoride rinse, gel or tablet	☐ denture adhesive
☐ powered brush	☐ toothpick	☐ mouth rinse	☐ other_____

Check the type of toothpaste you use:

☐ fluoride	☐ tartar control	☐ gum benefit	☐ whitening
☐ sensitivity protection	☐ baking soda	☐ peroxide	☐ multiple benefit

Estimate how long it takes you to clean your teeth and gums each time:
Brushing_____ Flossing_____

About how many times each day/week do you brush and floss?
I brush about ____times per day OR _____times per week
I floss about ____times per day OR _____times per week

☐Yes ☐No Do you have difficulty in adequately cleaning your teeth? (Check all that apply)
☐ Difficult to hold toothbrush ☐ Difficult to use dental floss ☐ Can't brush/floss for any length of time
☐ Don't see well ☐ Other/comments_____

☐ Yes ☐ No ☐Don't know Do you live in a fluoridated community?

☐ Yes ☐ No Do you use a water filter or bottled water for your main drinking water source?
If yes, type of filter_____ brand of water_____

BEHAVIORS/HABITS

☐ Yes ☐ No *Do you use smoking tobacco, chewing tobacco, marijuana, vaping, juuling, and/or hookah? If yes, what form and frequency?
Type (cigarettes, spit tobacco, smoke marijuana) _____ Frequency/quantity _____ How long? _____

☐ Yes ☐ No Do you consume alcohol? If yes, frequency/quantity_____

Check the sweets/starches you eat regularly. In the space next to each food, indicate how often you eat these each day:

☐ breath mints___	☐ soda/pop___	☐ chips___	☐ candy___
☐ cough drops___	☐ coffee or tea with sugar___	☐ crackers___	☐ dried fruits___
☐ chewing gum___	☐ other sugared beverages___	☐ cookies___	☐ other sweets_____

BELIEFS/ATTITUDES

How important is it for you to prevent cavities, gum problems or other disease of the mouth?
☐ Very important ☐ Somewhat important ☐ Not at all important

Would you like your dental professional to make specific product recommendations to meet your oral care needs?
☐ Yes ☐ I'm not sure ☐ No

I believe that I have control over the condition of my mouth. ☐ Firmly believe ☐ Somewhat believe ☐ Do not believe

PATIENT INFORMATION **Today's Date_____**

Female___ Male___

Name _____ **Single___ Married___ Minor___ AGE: _____**
Last First Middle I.

Mailing Address_____ Birthdate ___/___/___
Street Apt/Space# City State Zip Code

Contact Information: Telephone: ( ) _____ ( ) _____ ( ) _____ ( ) _____
Home # Work # Cell # Other (Message, Pager)

E-mail address: _____ (**optional**)

Text Messages: Would you like to receive text messages? ____ YES ____NO

NOTE: **these methods of contact will only *be used as contact for appointments and are never sold/shared/distributed in any manner outside the needs of our clinical appointment management needs*.**

FAMILY INFORMATION - Minor Child? {Fill in *BOTH blocks}* Married? {Fill in *APPROPRIATE block}*

Father (or Husband)- please circle	*Mother (or Wife) - please circle*
_____ *Last Name First Middle*	_____ *Last Name First Middle*
_____ Address : *Street City Zip Code*	_____ Address *: Street City Zip Code*
(__)_____ (___)_____ (____)_____ Home Telephone Work Telephone Cell Phone	(__)_____ (___)_____ (____)_____ Home Telephone Work Telephone Cell Phone
Birth Date (Month/Day/Year)_____	Birth Date (Month/Day/Year)_____

EMERGENCY CONTACT - Who shall we contact (friend/family) if you are in need of assistance while in our facility?

NAME_____RELATIONSHIP TO YOU_____

TELEPHONE # ( ) _____ ADDRESS_____
Street City Zip Code

DENTAL INFORMATION

Reason(s) for this dental appointment? ___ Cleaning ___Examination ___Emergency ___Consultation

Do you have a specific dental problem? ___Yes ___ No If yes, please explain: _____

Name of previous or current dentist: _____

Date of last dental x-rays: _____ 16 – 20 small films ____ Panoramic film___

AUTHORIZATION

I understand that Phoenix College Dental Programs and Clinic exist to teach students skills in dental assisting and dental hygiene, that all services offered in the clinic are for this purpose and that several appointments may be necessary for completion of treatment. I give permission for my patient records and photographs to be used in this educational setting.

I also understand that I am responsible for all costs and dental treatments I receive in this facility. Upon being informed of each procedure, I authorize the administration of such medications and performance of diagnostic and therapeutic procedures as may be necessary for appropriate dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

I have read and understand the information contained in the separate patient information sheet provided.

X _____ _____
Signature (If patient is a Minor, Parent or Guardian) Date Signed

Phoenix College
Department of Dental Programs

Dental Clinic

Important Information for Our Patients

Read and Sign

Dental Hygiene Clinic

Under instructor/dentist supervision, the dental hygiene students may perform the following procedures according to your needs:

- prophylactic cleaning of the teeth - *Most Appointments are **3 hours in length**, and usually takes more than one appointment*
- local anesthesia in conjunction with cleaning
- fluoride treatments
- radiographs (x-rays) of the dentition
- vital signs (blood pressure) and oral cancer examination
- home-care instruction including brushing and flossing
- photographs of the face and mouth

Note:

- only patients whose care is suitable for teaching purposes are eligible for continued treatment in the clinic
- children under the age of 18 must be accompanied by a parent or legal guardian
- individuals who have difficulty reading or speaking English must provide an interpreter at every appointment
- patients are responsible for scheduling recall appointments

Patient's Rights

Patients can expect:

- considerate, respectful, and confidential treatment
- an explanation of recommended treatment and treatment alternatives
- the option to refuse treatment
- access to complete and current information about your condition
- treatment that meets the standard of care in the profession
- referrals for treatment we are unable to provide

Our goal is to provide continuity and completion of treatment. *However, the educational setting makes it impossible for us to consistently provide long-term dental care.*

The Dental Clinic is open approximately 8 months out of the year. *We suggest and encourage you to maintain relationships with dental practitioners in the community to be sure all of your dental needs are met.*

Patient's Responsibilities

Patients are responsible for:

- being on time for your appointment
- being considerate and respectful
- paying for services at the time they are rendered
- signing a consent for treatment
- signing acknowledgment of this information

Termination of Clinician - Patient Relationship Policy

- It is the policy of the dental clinic to terminate the clinician-patient relationship when such a clinican-patient relationship has not been formed or is no longer proceeding in a mutually productive manner.

Sexual Harassment and Discrimination Policy

- The policy of the Maricopa County Community College District (MCCCD) is to provide an educational, employment, and business environment free of sexual violence, unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct or communications constituting Sexual Harassment as prohibited by state and federal law.

Refund Policy

If you choose to discontinue treatment and request a refund from Phoenix College Dental Clinic, you will be refunded:
$15.00 if radiographs were taken at any time during your dental visit(s)
$35.00 if no radiographs were taken
All Refunds will be processed back to the original form of payment through Phoenix College Cashiers Office in Hannelly Center on Phoenix College Campus. Please bring a current photo ID to Cashiers Office at 1202 W. Thomas Rd., Phoenix, AZ. 85013.

Cancellation Policy

- You will lose your appointment time if you are more than 15 minutes late
- We will be unable to schedule you in our facility if:
  - you cancel appointments twice with less than twenty-four (24) hours notice
  - you fail twice to keep an appointment

I have read and understand the information contained in this Patient Information Sheet.

X_____ ***Date*** _____

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by: _____

Printed Name-Patient or Responsible Party

_____

Patient Signature or Responsible Party Date

_____

Relationship to patient (if other than patient)

Complaints: You may complain to Phoenix College Dental Programs, Chairperson, (602)285-7262, Address: 3144 North 7th Avenue, Website: www.phoenixcollege.edu/dental. If you believe that your privacy rights have been violated, you may also complain to the Secretary of the United States Department of Health and Human Services.

Term of Notice: This notice is effective 9/18/18. The provisions of this notice may change. If they do, a current version of the notice will be published at the website noted above.

HIPAA Privacy Authorization Form

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: Relationship:

_____ _____

Contact information: _____

_____

Oral Health Information to be disclosed upon the request of the person named above (Check either A or B):

☐ A. **Disclose** my complete oral health record (including but not limited dental x-rays, clinical notations, dental hygiene diagnosis, prognosis, treatment, and billing)

OR

☐ B. **Disclose** my oral health record, as above, **BUT do not disclose** the following (check as appropriate):

- ☐ Dental x-rays
- ☐ Medical History information
- ☐ Clinical notations
- ☐ Dental/Periodontal charting information
- ☐ Oral health treatment provided
- ☐ Billing information
- ☐ Other (please specify): _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods
  OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your oral health care provider(s), preferably in writing.)

_____ _____

Name of the Individual Giving this Authorization Date of birth

_____ _____

Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

Phoenix College Dental Clinic | 3144 N 7th Ave | Phone: (602)285-7323 Fax: (602)285-7127

PHOENIX COLLEGE DENTAL CLINIC
1202 W. THOMAS ROAD (mailing address) 3144 North 7th Avenue (physical address)
PHOENIX, AZ 85013
PHONE: 602-285-7323
FAX: 602-285-7127

I (print name of patient) _____, Birth date _____
request the release of my dental records **dated**_____, including dental films/images, for diagnostic and hygiene treatment purposes.
X_____ Date: _____
(Patient's/Guardian's Signature)

This signature of request is applicable until revoked by the patient

---

{Check one below}
___ to the **Phoenix College Dental Clinic** for the purposes stated above. Digital images may be e-mailed to: pc-dental-images@phoenixcollege.edu.

___ to / request from: _____at: (Fax #)_____

(E-mail address):_____
Requested records sent by:_____ on: _____via: e-mail _____U.S. Postal ____
Request **for** records sent by: _____on: _____via: e-mail ____Fax ___USPS _____

SUBSEQUENT REQUESTS AND FORWARDING

Digital Images dated: _____ **Periodontal Charting dated:** _____
Notes/Comments: _____

To: (e-mail address):_____

Requested records sent by: _____ on: _____via: e-mail _____U.S. Postal ____
Request **for** records sent by: _____on: _____via: e-mail ____Fax ___USPS _____

Digital Images dated: _____ **Periodontal Charting dated:** _____
Notes/Comments: _____

To: (e-mail address):_____
Requested records sent by: _____ on: _____via: e-mail _____U.S. Postal ____
Request **for** records sent by: _____on: _____via: e-mail ____Fax ___USPS _____

Digital Images dated: _____ **Periodontal Charting dated:** _____
Notes/Comments: _____

To: (e-mail address):_____
Requested records sent by:_____ on: _____via: e-mail _____U.S. Postal ____
Request **for** records sent by: _____on: _____via: e-mail ____Fax ___USPS _____

11.19..2015/rak