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 home-care 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 when indicated. Dental hygiene treatment will be performed by a student and will be supervised by faculty. Treatment received in our clinic requires more time than in a private 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 a 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.

**Patient’s Rights and Responsibilities**

1. Patients of our facility will be given considerate, respectful and confidential treatment. Our goal is to complete any treatment started; however, as an educational facility, we must work within certain constraints and limitations. The educational setting makes it impossible for us to consistently provide patients with long-term dental 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 of 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 of recommended treatment, the cost of 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 reimbursement of fees.

**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.
All students and staff in our facility are trained in and required to follow strict infection control standards. These requirements follow:

1. Students and staff wash their hands with antimicrobial soap and put on fresh gloves for each patient.
2. Students and staff wear gloves, face masks and eyewear while treating patients. Patients are provided with protective eyewear during treatment.
3. All instruments are precleaned and heat sterilized to destroy all microbes.
4. Handpieces are sterilized following ADA and CDC guidelines.
5. Disposable equipment is used for each patient whenever possible. This includes suction devices, aspirating tips, plastic cups, needles, prophy cups, bibs, etc. These items are used once and then discarded.
6. All parts of the dental and x-ray units (including chairs and lights), are disinfected between each patient. Wherever possible, they are covered with clear plastic that is changed before the next patient is seated.
7. Counter tops are wiped down and sprayed with a disinfectant between each patient.
8. Proper hygiene habits are maintained by students and staff.
9. Hazardous waste is disposed in specialized receptacles and processed by an independent hazardous waste disposal company.
10. We update and implement infection control techniques recommended by the American Dental Association, Centers for Disease Control, and the Occupational Safety and Health Administration.

It is our hope that this information will answer many questions and ease any concerns that patients may have regarding the prevention of disease transmission in our facility.

Program policies for providing a safe dental environment are available upon request.

Phoenix College Dental Clinic
1202 W. Thomas Road - Phoenix, AZ 85013
(602) 285-7323
Dental Clinic

Important Information for Our Patients

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
• paying for services at the time they are rendered
• signing a consent for treatment
• signing acknowledgment of this information

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 ________________

Phoenix College
Department of Dental Programs

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.

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

X ___________________________ Date ________________

revised 09/06
PATIENT INFORMATION

Today's Date__________

Name __________________________________________

Last         First          Middle

Female___ Male___

Single___ Married___ Minor___ AGE:_______

AGE:_______

Birthdate ___/___/___

Mailing Address___________________________________________________________

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

________________________________________

Last Name                    First Middle

Address : Street                      City             Zip Code

( )__________ ( )__________ ( )__________

Home Telephone   Work Telephone   Cell Phone

Birth Date (Month/Day/Year)

Mother (or Wife) - please circle

________________________________________

Last Name                    First Middle

Address : Street                      City             Zip Code

( )__________ ( )__________ ( )__________

Home Telephone   Work Telephone   Cell Phone

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

8/16/10
Patient Name: ___________________________________________ Date: __________________

DOB: _______/_____/______

Name of Primary Care Physician: ____________________________ Phone: (______)______

Other physicians care 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 for each condition.

Yes  No

Heart Disease/Defect ☐ Pain in the Jaw ☐ Yes  No
Heart Murmur ☐ Cortisone Medication ☐
Irregular Heart Beat ☐ Swelling of Limbs ☐
Angina/Chest Pain ☐ Lung Disease ☐
Heart Attack ☐ Breathing Problems ☐
Heart Failure ☐ Shortness of Breath ☐
Rheumatic Fever ☐ Frequent Cough ☐
MitraI Valve Prolapse ☐ Hay Fever ☐
Artificial Heart Valve ☐ Sinus Trouble ☐
Heart Pacemaker ☐ Asthma ☐
Heart Surgery ☐ Emphysema ☐
High Blood Pressure ☐ Tuberculosis ☐
Low Blood Pressure ☐ Thyroid Disease ☐
Stroke ☐ Fainting/Dizziness ☐
Blood Disease ☐ Cancer ☐
Bruise Easily ☐ Tumor Growth ☐
Anemia ☐ Radiation Treatment ☐
Bleed Problems ☐ Chemotherapy ☐
Hemophilia ☐ Artificial Joint ☐
Leukemia ☐ AIDS ☐
Allergies to Drugs ☐ HIV Positive ☐
Allergies to Pollen/Dust ☐ Sexually Transmitted Infection ☐
Hives/Rash ☐ Osteoporosis/Osteopenia ☐

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

Date Updates None Patient’s Signature BP Pulse ASA DDS/DMD Initials

none

none

none

none

none

none

none
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
- abscess
- swelling inside mouth
- swollen face
- filling fell out
- sensitive teeth
- bad breath
- sore gums
- bleeding gums
- tartar buildup
- stains
- yellowing/graying teeth
- loose teeth
- dry mouth
- burning sensation
- difficulty chewing
- difficulty swallowing
- other

**Check any of the following you regularly use at home:**
- soft toothbrush
- hard toothbrush
- medium toothbrush
- powered brush
- special brush
- floss threader
- toothpick
- oral irrigator
- powered interdental cleaner
- mouth rinse
- rubber tip
- fluoride rinse, gel or tablet
- denture cleanser
- denture adhesive
- other

**Check the type of toothpaste you use:**
- fluoride
- tartar control
- sensitivity protection
- gum benefit
- whitening
- 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  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 tobacco in any form?  If yes, what form and frequency?
  Type (cigarettes, spit tobacco, etc)  - 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
- cough drops
- chewing gum
- soda/pop
- coffee or tea with sugar
- other sugared beverages
- chips
- crackers
- cookies
- candy
- dried fruits
- 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

PREVENTION SURVEY