

Santa Rosa Junior College  
DENTAL HYGIENE TEACHING CLINIC CONDITIONS OF TREATMENT

**GENERAL INFORMATION:** The Dental Hygiene Clinic at SRJC is primarily a teaching clinic; therefore patients receiving dental care will be participating in the teaching program. Treatment will be performed by dental hygiene students and will be supervised by members of the SRJC Dental Programs faculty. Treatment under supervision requires more time than if done in a private dental office and may require multiple appointments lasting approximately three hours each. You should continue to visit your general dentist on a regular basis for routine examinations and dental treatment. The SRJC Dental Hygiene Clinic may refuse to treat patients who do not have routine dental examinations or have dental disease which requires dental disease considerations falling outside our scope of treatment.

**APPLICATION TO BECOME A PATIENT:** Only patients whose care is suitable for teaching purposes are eligible for treatment in the SRJC Dental Hygiene Clinic. All patients require an initial evaluation to determine eligibility. It may be necessary for treatment to be performed by multiple students in order to complete treatment. SRJC reserves the right to deny acceptance into treatment in the SRJC Dental Hygiene Clinic if it is determined that a patient would not be an appropriate educational opportunity. It is your responsibility to keep your contact information current so that students may contact you.

**CONSENT TO DENTAL PROCEDURES:** Before receiving treatment, you should ask the student about the procedure(s) that she/he recommends you undergo, and ask any questions you may have before you decide whether or not to give your consent for the procedure(s) to be done. All dental procedures may involve risks or unsuccessful results and complications, and no guarantee is made as to result or cure. You have the right to be informed of any such risks as well as the nature of the procedure, the expected benefit, and the availability of alternative methods of treatment. You have the right to consent to or refuse any proposed procedure at any time prior to its performance. Conversely, Santa Rosa Junior College Dental Hygiene Clinic reserves the right not to perform specific treatment requested by you if it violates the standard of care in dentistry and/or dental hygiene care or does not contribute to the student's educational opportunity.

**PHOTOGRAPHS:** Patient photographs may be taken to document a condition, examination findings and/or for teaching purposes.

**FINANCIAL RESPONSIBILITIES:** Patients who receive treatment in the SRJC Dental Hygiene Clinic will be charged for treatment according to the fee schedule in the clinic. Fees are collected prior to beginning treatment and are non-refundable; patients must be prepared to pay for services before procedures begin. SRJC will not file any claims for dental insurance.

**DENTAL RECORDS:** The records, x-rays, photographs, and other materials relating to your treatment in the SRJC Dental Hygiene Clinic are the property of the SRJC Dental Programs. You have the right to inspect such materials or request copies in writing. We will comply within 15 business days. SRJC may charge a reasonable fee for this service. You may also request to have your dental x-rays sent to another health care provider. In addition, your medical/dental records may be used for instructional purposes and if they are, your identity will not be disclosed to individuals not involved in your care and treatment.

**KEEPING YOUR APPOINTMENTS:** Patients are required to be on time for their appointments. If you find that you are unable to keep an appointment, you must notify the student or clinic office at least 24 hours in advance. Cancellations without 24-hour notice, missed appointments, or repeated unsuccessful attempts to arrange for an appointment may be cause to discontinue a patient from further treatment in the SRJC Dental Hygiene Clinic.

**PRODUCT DISCLAIMER:** Dispensing of products does not constitute an endorsement from SRJC or the Dental Programs

Your signature on this form certifies that you have read and understand the information provided on the form, that you have received a copy, and that you accept dental hygiene care under the described terms and conditions.

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

If signed by other than the patient, indicate relationship: parent/guardian/conservator

**Privacy Policies and Practices of the Allied Dental Programs  
Santa Rosa Junior College**

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE OBTAINED/REVIEWED BY OUR FACULTY  
AND STUDENTS. PLEASE REVIEW IT CAREFULLY.

You are a valued participant in our educational program and we are vitally interested in protecting the privacy of our patients. To do so we have developed privacy policies and procedures. This notice describes how we safeguard this data so that your health information will not be compromised while you are a patient in our clinics.

- ❖ "Protected health information" is individually identifiable health information transmitted or maintained by electronic or other media.
- ❖ We use and disclose only the minimum protected health information to perform services for you. Examples of such use and disclosures are:

**Treatment**

We use and disclose health information to treat patients by way of health history forms and consent for treatment forms, and clinical records involved in the provision of all services provided by the students/faculty in the SRJC Dental Clinic. We may obtain this data from you directly or from another health care provider. We may disclose this health information to another health care provider or within our educational facility as it pertains to your treatment in the SRJC Dental Clinic.

**Operations**

We use and disclose protected health information for activities that are related to the educational requirements of the college, accreditation requirements and related curriculum. This may include calibrating the performance of our health care professionals, conducting training, accreditation, and licensing or credentialing activities.

**Authorization**

We may use protected health information for other purposes only if you have authorized us in writing to do so. However, we do not use patient health data in this way and will not ask your authorization to do so.

- ❖ **We limit how, when and where we may disclose protected health information. When we do so, we disclose only the minimum information required. Examples include:**

**Law**

We must disclose protected health information if required by law, a warrant or court order, or to report information about a crime victim.

**Public Health**

We may disclose protected health information to public health or government oversight agencies as authorized by law.

**Safety**

We may disclose protected health information to prevent a serious threat to the health and safety of a student or others from taking place.

**Government**

We may disclose protected health information as required by the military or federal government for national security and intelligence activities.

- \* We protect your rights regarding your office's protected health information. Patients have rights regarding their protected health information. These rights include:

**Access**

Patients may review and obtain a copy of the protected health information we keep.

**Accounting**

You may request that we account for any disclosures we have made of protected health information. This request must be in writing and may not be for a period longer than six years and not include dates before January 14, 2014.

**Restriction**

You may request that we restrict our disclosure of protected health information. However, we are not required to agree to this request if it has an impact on our ADA Commission on Accreditation Guidelines and Standards.

**Communications**

You may request that we communicate with you about our handling of protected health information in a certain manner, time or place. Your request must be in writing and we will honor all reasonable requests.

**Changes to our privacy policies and procedures**

We may change the policies and procedures contained in this notice. If we make a material change in our policies and procedures we will provide you with an updated copy of our privacy practices at your request.

**How to contact us regarding privacy**

If you have any questions about the privacy rights of patients or this notice, complaints about how we have protected the privacy of protected health information obtained by our students, or ideas how to best improve our privacy policies please contact the person listed below. If you believe that we have violated privacy rights you may contact the Secretary of the Department of Health and Human Services.

**Contact Person:** Lucinda Fleckner, RDHAP, MS  
Director: Dental Hygiene Education Program  
Santa Rosa Junior College  
1501 Mendocino Ave.  
Santa Rosa, CA 95401  
(707) 527-4583

**Patient's Bill of Rights**

As a patient in the Santa Rosa Junior College Dental Clinics, you can expect:

- |                                       |  |                 |
|---------------------------------------|--|-----------------|
| Professional Care                     | Treatment Without Discrimination                     | Respectful Care |
| Confidentiality of All Communications | To Have Your Concerns Heard                          |                 |
| To Understand Your Treatment Needs    | Treatment in a Safe Environment                      |                 |
| Quality Treatment                     | To Participate in All Decisions About Your Treatment |                 |
|                                       | To Have Access to Your Dental Records                |                 |

**HOW TO FILE A HEALTH INFORMATION PRIVACY COMPLAINT WITH THE OFFICE FOR CIVIL RIGHTS**

<http://www.hhs.gov/ocr/howtofileprivacy.htm>  
Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions Office for Civil Rights  
U.S. Department of Health & Human Services  
50 United Nations Plaza - Room 322  
San Francisco, CA 94102  
(415) 437-8310; (415) 437-8311 (TDD)  
(415) 437-8329 FAX

1501 Mendocino Avenue, Santa Rosa, CA 95401-4395 • (707)527-4271 • FAX (707)527-4426

**ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES**

I acknowledge receipt of the Privacy Practices and Patient Bill of Rights of Santa Rosa Junior College.

**ACKNOWLEDGMENT OF FERPA REGULATION**

Santa Rosa Junior College complies with FERPA and has strict policies and procedures in place governing student records and privacy. Photographs of Students are strictly prohibited while in the SRJC Dental Department Clinical Facility.

**CONSENT FOR USE, DISCLOSURE AND REQUESTED RELEASE OF PROTECTED HEALTH INFORMATION**

Having read and understood the Privacy Practices of Santa Rosa Junior College I hereby consent to the use and disclosure of my protected health information to carry out treatment and health care operations. I also consent to the release of my information upon my request, to the location of my choice. I understand that my records will be accessible for 7 years. I understand that I am not required to give this consent in order for the program to use my protected health information for treatment and health care operations. I also understand that I may revoke this consent in writing by submitting the revocation to the Program Director listed on the Privacy Practices notice. I further understand that if I decline to give my consent, or if I revoke it, the program will decline to perform procedures on me.

By signing below, I acknowledge that I have had the opportunity to read and ask questions regarding these policies and regulations:

**Dated:** \_\_\_\_\_

**Print Patient Name:** \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_

If you wish to revoke your consent for any of the above, please ask the front desk for a Revocation of Consent form

Note: Keep white copy of this document in patient chart. Yellow copy is for patient.

PATIENT INFORMATION, MEDICAL HISTORY, DENTAL HISTORY

The following information is requested for the purpose of rendering appropriate dental hygiene services and will be kept confidential

Legal Name: Last First Middle Init. Birthdate: Month / Day / Year

Preferred Name:

Address: Number and Street City State Zip Phone: ( )

Gender Assigned at Birth: Male / Female Gender Identity: Non-binary Prefer not to disclose Prefer to self-describe Preferred Pronouns: she/her/hers he/him/his they/them/theirs Other: Please specify

Race: What language are you comfortable speaking:

Best way to be reached: Phone Email: Other:

In case of emergency, please notify: Name Relationship Phone

How did you hear about the clinic? CIRCLE:

(1) Family/ friend (2) Advertisement (3) SRJC (4) Online (5)Dentist: (6) Other:

Medical History

1. How would you describe your general health?

Poor Fair Good

If poor, please explain:

2. Date of last medical examination:

month/year purpose of visit

Physicians/ Clinic name:

Address:

Phone:

In case of emergency, what hospital would you like to be transported to:

3. Is a physician now treating you or has a physician treated you within the last year?

Yes No

If yes, describe condition:

4. Do you /have you been told you require a Pre-medication before dental work?

Yes No

5. Major illnesses / Hospitalizations / Surgery?

Please list:

6. Is there a history of diabetes in your family?

Yes No

If yes, Identify family member

7. Do you have a disability of any kind? Yes No

Describe disability

8. Pregnant? Yes No

If yes, due date:

9. Diagnosed with sleep apnea? Yes No

If yes, do you use a CPAP? Yes No

Is there anything we can do to make your visit with us more comfortable?

For Clinician Use:

Initial Vitals: BP: P R

Stage: ASA Classification:

W/O Modifications

W/ Modifications to Tx



**PATIENT INFORMATION, MEDICAL HISTORY, DENTAL HISTORY**

The following information is requested for the purpose of rendering appropriate dental hygiene services and will be kept confidential

**DENTAL HISTORY**

What is the reason for your visit? \_\_\_\_\_  
 \_\_\_\_\_

1. How would you describe your oral health  
 Poor  Fair  Good If poor please explain: \_\_\_\_\_  
 \_\_\_\_\_

2. Dentist Name: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Email: \_\_\_\_\_

3. Date of last dental exam: \_\_\_\_\_  
 Month/ Year

Purpose of exam? \_\_\_\_\_

4. Date of last dental cleaning: \_\_\_\_\_  
 Month/ Year

5. Date of last dental x-rays: \_\_\_\_\_  
 Circle: Bitewings FMX Panoramic Month/ Year

6. Frequency of dental check-ups:  
 6mo.  Yearly  Other \_\_\_\_\_

7. Have you ever had x-ray treatment other than dental x-rays?  
 Yes  No If yes, Reason: \_\_\_\_\_

8. What type(s) of anesthetics were used for any previous dental treatment?  
 Xylocaine(shots)  Nitrous Oxide (gas)  
 General Anesthetic  Other \_\_\_\_\_

9. Have you ever had unusual reaction to dental anesthesia?  
 Yes  No If yes, more than once?  Yes  No

10. Are you nervous about receiving dental treatment?  
 Yes explain why \_\_\_\_\_  No

11. Following dental treatment, have you ever had bleeding Problems?  
 Yes  No If yes, what corrective measures were required? \_\_\_\_\_

12. Does anyone in your family wear dentures?  Yes  No  
 If yes, reason for tooth loss: \_\_\_\_\_

**Have you ever had/ do you have: (check correct answer)?**

13. Difficulty chewing  Yes  No

14. Difficulty opening your mouth wide  Yes  No

15. Problems clenching or grinding your teeth  Yes  No

16. Injury to face, teeth, jaws  Yes  No

17. Sensitive teeth  Yes  No

18. Acute sore mouth or gum boils  Yes  No

19. Fever blisters/ sores (slow to heal?)  Yes  No

20. Orthodontic treatment (braces)  Yes  No

21. Periodontal (gum) treatment  Yes  No

22. Endodontic (root canal) treatment  Yes  No

23. Dental implants  Yes  No

24. Prosthesis (multiple tooth replacement)  Yes  No

25. Plaque control instructions (use of floss etc.)  Yes  No

26. Tooth-colored fillings or restorations  Yes  No

27. Nutritional Counseling  Yes  No

**Do you ever:**

28. Think your teeth are affecting your general health  
 In any way?  Yes  No

29. Feel dissatisfied w/ the appearance of your teeth?  
 Yes  No

30. Frequently bite your lips or cheeks or objects?  
 Yes  No

31. Do you have any mouth or facial piercings?  Yes  No

32. Why do you feel it is important to have your teeth cleaned?

Calculus (tartar) needs to be removed

Stain needs to be removed

I cannot keep my own teeth cleaned

Other \_\_\_\_\_

33. What do you feel is your major dental problem?  
 Not aware of any at this time  Caries (tooth decay)

Periodontal (gum) disease  Other

Teeth need straightening

34. What type of toothbrush do you use?  
 Soft  Med.  Hard  Electric  Don't know

35. What type of toothpaste do you use?  
 Fluoride  Non-Fluoride  Don't know  Other

36. How often do you brush your teeth?  
 1x/day  2x/day  Other Duration: \_\_\_\_\_ minutes.

37. How often do you floss?  daily  occasionally  do not.

38. What additional cleaning devices do you use?  
 Water Pik  Perio aid  Proxabrush  
 Floss holder  Stimudents/toothpicks  Other \_\_\_\_\_

39. Have you benefitted from fluoride in any of the following?  
 Drinking water  Tablets  Toothpaste

Dental Office  Mouthwash

40. When do you eat foods containing sugars?  
 All the time  At different times each day  
 At meals  Do not eat sweets

**I attest to the fact that the foregoing medical and dental histories are factual and complete. I hereby request and authorize the rendering of dental hygiene services.**  
 (Parent of guardian's signature required for children under age 18)

\_\_\_\_\_  
 Signature of patient or guardian Date

\_\_\_\_\_  
 First name/ Last initial of DH student DH#

Faculty Name \_\_\_\_\_ Date \_\_\_\_\_

Clinical Dentist \_\_\_\_\_ Date \_\_\_\_\_