SANTA ROSA JUNIOR COLLEGE
Dental Programs

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.

Name: _____ **Birthdate**_____/_____/_____
Last First Middle Initial *Month Day Year*

Address: _____ **Phone**( )_____
Street & number City State Zip

Gender Assigned at Birth: Male / Female
Gender Identity: Non-binary_____ Prefer not to disclose_____ Prefer to self-describe_____

What pronouns do you prefer that we use when talking about you?

_____She/her/hers ____ He/him/his ____ They/them/theirs ____ Other: Please specify: _____

What Language are you most comfortable speaking? _____

Best way to be reached: Phone message_____ Email: _____ Other_____

In case of emergency, please notify: _____ (_____) ( )_____
Name. Relationship Phone number

How did you hear about the clinic? CIRCLE

(1) Family/friend (2) Advertising (3) Santa Rosa Junior College (4) Online (5) Dental office name:_____

(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*

   For Clinician Use:
   Initial vitals: BP_____ **P**_____ **R**_____
   Stage_____ **ASA Classification**_____
   W/O modifications ___ ***W/modifications to Tx***_____
   _____

   Physicians/Clinics 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_____
   Describe condition

4. Major illnesses / Hospitalizations / Surgery
   Please list _____

5. Is there a history of diabetes in your family?
   ☐ yes ☐ no_____
   If yes, identify family member

6. Do you have a disability of any kind?
   ☐ yes ☐ no_____
   Describe disability

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Have you become sick from, shown allergy to, or been told not to take any of the following:

Drug			List Specific Drug
7. Antibiotics *(penicillin, etc.)*	☐ yes	☐ no	____________
8. Novacaine/dental anesthetic	☐ yes	☐ no	____________
9. Latex or Sulfites *(circle)*	☐ yes	☐ no	____________
10. Other drugs or medicines	☐ yes	☐ no	____________

Have you ever had or are you taking medicines for?

11. Allergy ☐ yes ☐ no
12. Arthritis or rheumatism ☐ yes ☐ no
13. Auto-immune disease / syndrome ☐ yes ☐ no
14. Birth control / menopause *(hormones)* ☐ yes ☐ no
15. Blood *(Liver or iron supplements, etc.)* ☐ yes ☐ no
16. Blood thinning *(anticoagulants)* ☐ yes ☐ no
17. Diabetes *(pill or "shots")* ☐ yes ☐ no

If yes:

What type?...Type I _____ Type II_____

Have you eaten today?...yes______ No______

What was your glucose count this morning? ______________________

18. Epilepsy / convulsions *(anticonvulsants)* ☐ yes ☐ no
19. Headaches ☐ yes ☐ no
20. Heart or blood pressure ☐ yes ☐ no
21. anxiety / depression / sleeping ☐ yes ☐ no
22. Stomach trouble *(ulcer or other)* ☐ yes ☐ no
23. Thyroid condition ☐ yes ☐ no
24. Are you now wearing contact lenses? ☐ yes ☐ no
25. On a prescribed diet *(low sodium, etc.)* ☐ yes ☐ no
26. Using tobacco *(smoking, chewing, vaping)* ☐ yes ☐ no

If yes, type:________________amount ______________

27. Are you currently using Marijuana? ☐ yes ☐ no
28. Antibiotic pre-medication before dental work ☐ yes ☐ no
29. Taken Fen-Phen or Redux *(diet pills)* ☐ yes ☐ no
30. Heart or vascular disease ☐ yes ☐ no
31. Cardiac surgery ☐ yes ☐ no
32. Valvular prosthesis ☐ yes ☐ no
33. Pacemaker ☐ yes ☐ no
34. Heart attack ☐ yes ☐ no
35. Stroke ☐ yes ☐ no
36. Rheumatic heart disease /rheumatic fever ☐ yes ☐ no
37. Heart murmur / Mitral valve prolapse ☐ yes ☐ no
38. Congenital heart disease ☐ yes ☐ no
39. Kidney disease ☐ yes ☐ no
40. Organ transplant ☐ yes ☐ no
41. Blood transfusion ☐ yes ☐ no
42. Hypoglycemia ☐ yes ☐ no
43. Hyper / hypothyroid ☐ yes ☐ no
44. Prosthetic joint replacement ☐ yes ☐ no
45. Lung trouble *(TB, emphysema, asthma)* ☐ yes ☐ no

   Do you have your inhaler with you? Yes___ No ___

46. Blood disease *(Anemia, leukemia, etc)* ☐ yes ☐ no
47. Excessive bleeding / bruising ☐ yes ☐ no
48. Fainting spells / convulsions / epilepsy ☐ yes ☐ no
49. Psychotherapy ☐ yes ☐ no
50. Drug-alcohol dependence or I.V. drugs ☐ yes ☐ no
51. Tumor or cancer ☐ yes ☐ no
52. Radiation / chemotherapy ☐ yes ☐ no
53. Steroid therapy *(cortisone, etc.)* ☐ yes ☐ no
54. Hepatitis / liver disease / jaundice ☐ yes ☐ no
55. STD *(syphilis, gonorrhea, herpes)* ☐ yes ☐ no
56. HIV positive or AIDS ☐ yes ☐ no
57. Taken bisphosphonate *(Actonel, Boniva, Fosamax)* ☐ yes ☐ no

Pregnant? ☐ yes ☐ no

If yes, due date: ______________________

58. Please list any other condition you feel we should know:

____

____

____

____

59. Please list any / all medicines, herbal or homeopathic remedies you are using at this time including recreational drugs: (attach a separate list if needed)

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SANTA ROSA JUNIOR COLLEGE
Dental Programs

PATIENT INFORMATION, MEDICAL HISTORY, DENTAL HISTORY

DENTAL HISTORY

What is the main reason for your visit?_____

1. How would you describe your oral health?
☐ Poor ☐ Fair ☐ Good If Poor:
Explain:_____

2. Date of last dental examination:
_____ _____
month / year *purpose of visit*

3. Date of last dental cleaning? _____
month / year

4. Date of last dental x-rays _____
Circle: *Bitewings FMX Pano month / year*

5. Frequency of dental check-ups:
☐ 6 mos. ☐ yearly ☐ Other _____

6. Dentist Name:_____ Phone #:_____
Address:_____

7. Have you ever had x-ray treatment other than dental x-rays?
☐ yes ☐ no 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 an unusual reaction to dental anesthesia? (gas or shots) ☐ 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, _____
Corrective measures required

12. Does anyone in your family wear dentures?
☐ yes ☐ no _____
If yes, reason for tooth loss

Have you ever had: (check the correct answer)?

13. A traumatic dental experience	☐ yes	☐ no
14. Difficulty chewing your food	☐ yes	☐ no
15. Difficulty opening your mouth wide	☐ yes	☐ no
16. Problems clenching or grinding your teeth	☐ yes	☐ no
17. Injury to face, teeth, jaws	☐ yes	☐ no
18. Sensitive teeth	☐ yes	☐ no
19. Bleeding gums	☐ yes	☐ no
20. Acute sore mouth or gum boils	☐ yes	☐ no
21. Fever blisters on lips or mouth	☐ yes	☐ no
22. Sores on lips or mouth that were slow to heal	☐ yes	☐ no
23. Orthodontic treatment *(braces)*	☐ yes	☐ no
24. Periodontal *(gum)* treatment	☐ yes	☐ no
25. Endodontic *(root canal)* treatment	☐ yes	☐ no
26. Prothesis *(tooth replacement)*	☐ yes	☐ no
27. Plaque control instructions *(use of floss, etc.)*	☐ yes	☐ no
28. Nutritional counseling	☐ yes	☐ no
29. Tooth-colored fillings or restorations	☐ yes	☐ no
30. Dental implants	☐ yes	☐ no

Do you ever:

31. Think your teeth are affecting your general health in any way?	☐ yes	☐ no
32. Feel dissatisfied with the appearance of your teeth?	☐ yes	☐ no
33. Worry about receiving dental treatment?	☐ yes	☐ no
34. Frequently bite your lips or cheeks?	☐ yes	☐ no
35. Frequently bite objects such as a nails, thread, etc.?	☐ yes	☐ no
36. Do you have any mouth or facial piercings?	☐ yes	☐ no

37. 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 _____

38. What do you feel is your major dental problem?
☐ Not aware of any at this time
☐ Caries *(tooth decay)*
☐ Periodontal (gum) disease
☐ Teeth need straightening
☐ Other _____

39. What type of toothbrush do you use?
☐ Soft ☐ Medium ☐ Hard ☐ Don't know
☐ Electric toothbrush

40. What type of toothpaste do you use?
☐ Fluoride ☐ Non-fluoride ☐ Don't know
☐ Other _____

41. How often do you brush your teeth?
☐ Once a day ☐ Twice a day ☐ Other _____

42. How long do you brush? _____ minutes

43. How often do you use dental floss?
☐ Daily ☐ Occasionally ☐ Do not use at this time

44. What additional cleaning devices to you use?
☐ Water Pik ☐ Perio aid ☐ Proxabrush ☐ Floss holder
☐ Stimudents/toothpicks ☐ Other _____

45. Have you benefited from fluoride in any of the following?
☐ Drinking water ☐ Tablets ☐ Toothpaste
☐ Dental office ☐ Mouthwash

46. You most often eat foods containing sugar
☐ All the time ☐ At different times during the day
☐ At meals ☐ Do not eat sweets

47. Is there anything that can be done to make your visit with us more comfortable? _____
_____

48. Do you use tobacco products (cigarettes, pipe, vape)? ☐ yes ☐ no

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 or guardian's signature required for children under age18).

_____ _____
Signature of patient or guardian *Date*

_____ _____
First Name & last initial of Dental Hygiene Student *DH#*

*Faculty Name*_____ *Date*_____

*Clinical Dentist*_____ *Date*_____

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; 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

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge receipt of the Privacy Practices of Santa Rosa Junior College and acknowledge that I have had the opportunity to read this description of their privacy practices and ask questions regarding their privacy practice.

Dated: _____ Print Patient Name: _____

Signature of Patient:

The patient, (name) _____ was provided a copy of this Acknowledgement of Receipt of Privacy Practices and has either been unable to sign, or has refused to sign it.

Dated: Lead Faculty Signature:

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.

Dated: _____ Print Patient Name: _____

Signature of Patient:

REVOCATION OF CONSENT

I hereby revoke the consent for Santa Rosa Junior College to use my protected health information, which I gave on (date) _____. I understand that the program will decline to treat me.

Dated: _____ Signature of patient: _____

NOTE: keep copy of this document in patient chart

2017