SRJC Health History Form

Name: _____ Home Phone (___) _____Cell Phone (___) _____
Last First Middle

Address _____ City _____ State ____ Zip Code _____
P.O. Box or mailing address

Occupation _____ Business Phone _____ Date of Birth __ / __ / __ Sex: □ M □ F

Email _____ Text message _____

Emergency Contact _____ Relationship _____ Phone: _____

If you are completing this form for another person, what is your relationship to that person? _____
Your name Relationship

For the following questions, please circle **YES/ NO/ DON'T KNOW** or write in the appropriate response. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit your assigned student will follow-up with questions about your responses and they may ask additional questions concerning your health. This information is vital to allow us to provide appropriate and safe care for you. SRJC does not use this information to discriminate.

What is the main reason for your visit? _____

Medical Information:

1. How would you rate your health? □ Good □ Fair □ Poor
2. Has there been any change in your general health within the past year? ..... **Yes No Don't Know**
   If yes, explain _____
3. My last physical examination was on _____
4. Are you under the care of a physician? ..... **Yes No Don't Know**
   If so, what is the condition being treated? _____
5. The name and address of my physician(s) is
   Name: _____Phone: _____
   Street Address: _____
   City/State/Zip:_____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... **Yes No Don't Know**

If so, what was the illness or problem? _____

Are you taking or have you recently taken any of the following medications?

a. Antibiotics or sulfa drugs..... **Yes No Don't Know**
b. Anticoagulants (blood thinners)..... **Yes No Don't Know**
c. High Blood Pressure Medication..... **Yes No Don't Know**
d. Steroids ..... **Yes No Don't Know**
e. Aspirin ..... **Yes No Don't Know**
f. Bisphosphates ..... **Yes No Don't Know**
g. Insulin, tolbutamide ..... **Yes No Don't Know**
h. Digitalis ..... **Yes No Don't Know**
i. Nitroglycerin ..... **Yes No Don't Know**
j. Antihistamine ..... **Yes No Don't Know**

8. Are you taking any medication(s) including non-prescription and herbal medications? If so, what medicine(s) are you taking?
   Prescribed: _____
   _____
   _____
   _____
   Over the Counter: _____
   _____
   Natural/herbal preparations:_____
   _____

9. Do you have active Tuberculosis? ..... **Yes No Don't Know**
10. Do you have a persistent cough greater than a 3 week duration or cough that produces blood?..... **Yes No Don't Know**

Bleeding Problems:

11. Have you had abnormal bleeding? ..... **Yes No Don't Know**
12. Have you ever had a blood transfusion? ..... **Yes No Don't Know**
    If yes, when? _____
13. Do you have a blood disorder?
    (anemia, hemophilia, leukemia) ..... **Yes No Don't Know**
    If yes, please explain_____

Premedication (Antibiotic)

14. Has a dentist or physician ever recommended that you take antibiotics prior to dental treatment? ..... **Yes No Don't Know**
    If yes, for what condition? _____
15. Do you have any of the following medical problems?
    a. Prosthetic cardiac valve ..... **Yes No Don't Know**
    b. Previous endocarditis ..... **Yes No Don't Know**
    c. Congenital heart disease, unrepaired, including palliative shunts and conduits ..... **Yes No Don't Know**
    d. Congenital heart disease, repaired, with prosthetic device ..... **Yes No Don't Know**
    e. Cardiac transplantation ..... **Yes No Don't Know**
16. Have you had an orthopedic total joint (knee, hip or other joint) replacement? ..... **Yes No Don't Know**
    If yes, date of surgery? _____
    a. For this condition, has your surgeon directed you to take antibiotics before dental treatment? **Yes_____ No _____**

Cardiovascular Diseases:

17. Have you had a heart attack? ..... **Yes No Don't Know**
    If yes, when? _____
18. Have you had a stroke? ..... **Yes No Don't Know**
    If yes, when? _____
19. Do you have chest pain upon exertion? ..... **Yes No Don't Know**
20. Are you ever short of breath after mild exercise or when Lying down? ..... **Yes No Don't Know**
21. Do you have a Cardiac pacemaker? ..... **Yes No Don't Know**
22. Do you have any of the following cardiovascular problems?
    a. Coronary insufficiency ..... **Yes No Don't Know**
    b. Angina ..... **Yes No Don't Know**
    c. High blood pressure ..... **Yes No Don't Know**
    d. Low blood pressure ..... **Yes No Don't Know**
    e. Arteriosclerosis ..... **Yes No Don't Know**

Diabetes

23. Do you have Diabetes? ..... **Yes No Don't Know**

If Yes, please answer the next three questions:

What type? ..... Type I_____ Type II_____

Have you eaten today? ..... Yes _____ No _____

What was your glucose count this morning? _____

_____

Other Diseases

24. Have you ever had any treatment for a tumor or growth (surgery, Radiation, or chemotherapy)? ..... **Yes No Don't Know**

If yes, please explain _____

25. Do you have or have you had any of the following diseases or problems?

a. Asthma or hay fever ..... **Yes No Don't Know**
Do you have your inhaler with you? **Yes_____ No _____**

b. AIDS or HIV infection ..... **Yes No Don't Know**

c. Arthritis, rheumatism ..... **Yes No Don't Know**

d. Cancer ..... **Yes No Don't Know**

e. Chronic pain ..... **Yes No Don't Know**

f. Eating disorder ..... **Yes No Don't Know**

g. Epilepsy ..... **Yes No Don't Know**

h. Fainting spells or seizures ..... **Yes No Don't Know**

i. G.E. reflux ..... **Yes No Don't Know**

j. Glaucoma ..... **Yes No Don't Know**

k. Hepatitis, jaundice, or liver disease ..... **Yes No Don't Know**

l. Kidney trouble ..... **Yes No Don't Know**

m. Mental health problems ..... **Yes No Don't Know**

n. Mononucleosis ..... **Yes No Don't Know**

o. Oral herpes/ cold sores/ fever blister..... **Yes No Don't Know**

p. Osteoporosis ..... **Yes No Don't Know**

q. Persistent swollen glands in neck ..... **Yes No Don't Know**

r. Problems of the immune system ..... **Yes No Don't Know**

s. Recurrent infections ..... **Yes No Don't Know**

t. Respiratory problems ..... **Yes No Don't Know**
If yes, please specify type (emphysema, bronchitis, other)
_____

u. Severe headaches ..... **Yes No Don't Know**

v. Sexually transmitted disease (syphilis, gonorrhea, Chlamydia, etc.) ..... **Yes No Don't Know**

w. Sinus trouble ..... **Yes No Don't Know**

x. Stomach ulcer or hyperacidity ..... **Yes No Don't Know**

y. Systemic lupus erythematosus ..... **Yes No Don't Know**

z. Thyroid problems ..... **Yes No Don't Know**

Allergies

26. Are you allergic or have you had a reaction to:

a. Aspirin ..... **Yes No Don't Know**
If yes, specify reaction _____

b. Barbiturates ..... **Yes No Don't Know**
If yes, specify reaction _____

c. Codeine or other narcotics ..... **Yes No Don't Know**
If yes, specify reaction _____

d. Food ..... **Yes No Don't Know**
If yes, specify food and reaction _____

e. Iodine ..... **Yes No Don't Know**
If yes, specify reaction _____

f. Latex ..... **Yes No Don't Know**
If yes, specify reaction _____

g. Local anesthesia ..... **Yes No Don't Know**
If yes, specify reaction _____

h. Penicillin ..... **Yes No Don't Know**
If yes, specify reaction _____

i. Seasonal allergies ..... **Yes No Don't Know**
If yes, specify reaction _____

j. Sulfa drugs ..... **Yes No Don't Know**
If yes, specify reaction _____

k. Other .....**Yes No Don't Know**
If yes, specify reaction _____

27. Do you have any disease, condition, or problem not listed That I should know about? ..... **Yes No Don't Know**
If so, explain _____

Tobacco/ alcohol/ Drugs/ Vaping

28. Do you use tobacco of any type? ..... Yes _____ No _____
If so, which type? _____

29. Are you a former tobacco user? ..... Yes _____ No _____

30. Do you currently use alcoholic beverages? ... Yes _____ No _____

31. Are you in recovery for alcoholism/substance Abuse? ..... Yes _____ No _____

32. Do you use recreational drugs? ..... Yes _____ No _____

33. Do you use medical marijuana? ..... Yes _____ No _____

For Women Only:

34. Are you pregnant? ..... Yes _____ No _____
If yes, due date? _____

35. Are you taking birth control (pills, injections, or implants)? ..... Yes _____ No _____

36. Are you taking hormone replacement? ..... Yes _____ No _____

I certify that I have read and understand the above. I Acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold SRJC, or any member of the staff, or student, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ Initial vitals: BP_____ P_____ R_____

Signature of Patient/Legal Guardian Date Stage _____ ASA Classification_____

Relationship to Patient _____

Student Name/# _____ Date_____ Student Signature _____

Faculty Signature _____Date _____ DDS Signature _____

SRJC Dental History Form

Patient Name _____ **Date:** _____

1. The name and address of my dentist is:

   Name _____ Phone _____

   Street Address _____ City/State/Zip _____

2. Date of last dental cleaning _____ Date of your last dental x-rays _____
3. Are you nervous about receiving dental treatment?
   Yes _____ Explain why _____ No _____

4. Are you experiencing any of the following symptoms (Circle any that apply)

My teeth are Sensitive to:		**I have (an):**	**I am worried about:**
Hot	Abscess	Difficulty Chewing	Gum Recession
Cold	Toothache/Broken Tooth	Difficulty Swallowing	Dry mouth
Sweet	Burning Sensation	Calculus Buildup	Bad Breath
Pressure	Filling that fell out	Other Concern: _____	

5. Have you experienced any of the following? When (month/year)?
   Root Planning_____ Head/neck radiation therapy _____ Bad reaction to a local anesthetic_____
   Root Canal _____ Periodontal Surgery _____ Headaches, earaches or neck pains _____
   Tooth extraction _____ Prolonged bleeding after? Yes___ No___ Other_____
6. Have you ever had orthodontic (braces) treatment? Yes___ If yes, for how long? _____ No _____
   Did you wear a retainer? Yes ___ Permanent or removable? _____ No _____
7. Do you wear a removable dental prosthesis (denture, partial)? Yes_____ No _____
8. Do you have any dental implants? Yes_____ No _____
9. Do you clench or grind your teeth in the daytime or at night? Yes _____ No_____
   If yes, do you wear a night guard/bite guard? Yes_____ For how long? _____ No _____
10. Have you experienced any injuries to your teeth, face or jaw?
    Yes _____ Explain _____
    No _____
11. About how many times each day/week do you brush and floss?
    Brush: _____ x per day OR _____ x per week **Floss:** _____ x per day OR _____ x per week

12. Do you agree or disagree with this statement: Oral health affects general health.
    Strongly agree Agree Disagree Strongly Disagree

13.

When you look inside your mouth, do you look for any of the following?	Yes	No	Don't Know How
Caries			
Oral Cancer			
Cold Sores			
Gingival Disease			

14. In the past two years, have you been concerned about your breath or the appearance of your teeth or face?

Yellowing/ greying teeth	Spacing between teeth	Other
Stains	Gingiva	Breath

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 or accept credit or debit cards.

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

SANTA ROSA JUNIOR COLLEGE

Department of Health Sciences

Dental Clinic – Dental Hygiene and Dental Radiology

Patient's Bill of Rights

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

Professional Care

Treatment without Discrimination

Confidentiality of All Communications

To Have Your Concerns Heard

To Understand Your Treatment Needs

Respectful Care

Treatment in a Safe Environment

To Have Access to Your Dental Records

To Participate in All Decisions about Your Treatment

Quality Treatment

Declaraci6n De Derechos Para Pacientes

Como paciente de las Clinicas Dentales de Santa Rosa Junior College, puede contar con:

Atenci6n Profesional

Tratamiento sin Discriminaci6n

Confidencialidad en Toda Comunicaci6n

Sus Preocupaciones Sean Escuchadas

Entender las Necesidades de Su Tratamiento

Atenci6n Respetuosa

Tratamiento en un Medio Ambiente Fuera de Peligro

Participar en Todas las Decisi6nes de su Tratamiento

Tener Acceso a Sus Registros Dentales

1501 Mendocino Avenue, Santa Rosa, CA 95401-4395 • (707)527-4445 • FAX (707)524-1856

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

https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html

Region IX - San Francisco (American Samoa, Arizona, California, Guam, Hawaii, Nevada)
Michael Kruley, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (415)437-8310
FAX (415)437-8329
TDD (415)437-8311

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