APPENDIX CP 2

Phoenix College Dental Clinic
Important Information for Our Patients

V@æ}\Áˆ[˘Á~[¦Á&@[[•ã}*Áæ}Á^å˘&æcã[}æ|Á~æ&ã|ãcˆÁ~[¦Áˆ[˘¦Áå^}cæ|Á}^^å•ÈÁÁU˘¦ÁÖ^}cæ|Á
Œ••ã•cã}*Áæ}åÁÖ^}cæ|ÁP^*ã^}^ÁÚ¦[*¦æ{•Áæ¦^Áæ&&¦^åãc^åÁà^Ác@^ÁÔ[{{ã••ã[}Á[}ÁÖ^}cæ|Á
Œ&&¦^åãcæcã[}Á[~Ác@^ÁŒ{^¦ã&æ}ÁÖ^}cæ|ÁŒ••[&ãæcã[}Áæ}åÁ¸^Ácæ\^Á]¦ãå^Áã}Á[~~^¦ã}*Áå^}cæ|Á&æ¦^Á
c@æcÁ{^^c•Ác@^Á@ã*@^•cÁ•cæ}åæ¦å•Á[~Ác@^Á]¦[~^••ã[}•ÈÁÁY^Á¸[˘|åÁ|ã\^Ác[Ácæ\^Ác@ã•Á
[]][¦c˘}ãcˆÁc[Á^¢]|æã}Ác@^Á][|ã&ã^•Áæ}åÁ]¦[&^å˘¦^•Á[~Á[˘¦Á&|ã}ã&æ|Ác^æ&@ã}*Á~æ&ã|ãcˆÈÁ

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.

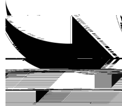
________ Right and Responsibilities

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.



______________________________________ _______________

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 Calculus Class: L M H H+

Preliminary Perio. Classification: 0 I II III IV

Estimated # of appointments ____________
Patient is ineligible ____________

Treatment Considerations / Comments ____

____

____

Student ____________________ Faculty ____________________________ Date ___________

Radiography Order: ____NONE____FMS-HBW ___

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						
☐	☐		☐	☐	Tumor Growth	☐	☐	Alcohol Addiction
☐	☐	Anemia	☐	☐	Radiation Treatment	☐	☐	Psychiatric Care
		Bleed Problems			Chemotherapy			

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 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?

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 #

Dental Hygiene Clinic

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

HIPAA Privacy Authorization Form

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** (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: ______________________

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 _____