

Phoenix College Dental Clinic Important Information for Our Patients



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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.



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	
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been hospitalized or had a major operation? Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or neck? Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking any medications, pills or drugs? List _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking any herbal supplements? List _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you taking any vitamins? List _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever taken fen-phen? _____
<input type="checkbox"/>	<input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Defect	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Bleed Problems

<input type="checkbox"/>	<input type="checkbox"/>	Tumor Growth
<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy

<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Addiction
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care

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 _____

HEMOCARE 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~~ 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 _____

Name _____
Last First Middle I. Female___ Male___
Single___ Married___ Minor___ AGE: _____

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
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 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~~ **Phoenix College Dental Clinic**

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 _____