Clayton State University's Dental Hygiene Clinic

Patient Information Sheet

Date:

Gender: Select

Title: Select

First Name: **Last Name:** **Suffix:**

Preferred Name: **Date of Birth:**

Cellphone Number: **Home phone:**

Work phone/EXT:

Mailing Address

Street: **City:** **State:**

Zip code:

Email Address:

How did you learn of us:

Marital Status: Select

Appointment Preference: Select

Available for short notice appointment calls: Select

If you are completing this for someone other than yourself, please share your name and relationship:

For your convenience, our clinic may communicate by email, text messages, and/or phone calls. Please indicate your preferred contact method and any objections you may have: Select

Emergency Contact Information

Contact Name: **Phone number:**

Relationship to you:

CLAYTON STATE UNIVERSITY

Department of Dental Hygiene

MEDICAL HISTORY

Date:

Personal Information

Patient Name:			Home #
Street Address:			Work #
City, State, & Zip Code:			Cell #
Date of Birth:	Height:	Weight:	Gender:
Email Address:			Marital Status SELECT ONE

Ethnicity SELECT ONE

Emergency Contact Information

Contact Name:	Home #
Relationship:	Cell #
If you are completing this form for the patient, what is your relationship to the patient?	

Please answer all the questions. All information provided by you is for our records and will be confidential

General Health Questions

Are you in good health? ☐ Yes ☐ No

When was your last physical exam?

If YES to any of the following questions, please explain further.

Are you currently under a physician's care? ☐ Yes ☐ No *If yes:*

Have you ever been hospitalized or has a serious illness? ☐ Yes ☐ No *If yes:*

Have you ever had any excessive bleeding? ☐ Yes ☐ No *If yes:*

Are you in recovery status from substance abuse? ☐ Yes ☐ No *If yes:*

Have you ever taken Fosamax, Boniva, Actonel, or any other medications Bisphosphonates? ☐ Yes ☐ No *If yes:*

Physician or Hospital Information *Please provide you PHYSICIAN and/or hospital information*

Physician's Name:	Street Address:
Phone Number:	City, State, & Zip Code:

Current and Past Health Conditions *Do you have/had any of the following conditions?*

Abnormal Bleeding ☐ Yes ☐ No	Eating Disorder ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	HIV/AIDS ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sexually Transmitted Disease ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Infective Endocarditis ☐ Yes ☐ No	
Artificial Joints ☐ Yes ☐ No	Fainting Spells/ Dizziness ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No		Liver Disease ☐ Yes ☐ No	Sickle Cell Trait Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No		Sinus Problems ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Steroid Therapy ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Hearth Attack/Failure ☐ Yes ☐ No	Lupus ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Hearth Murmur ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Substance Abuse ☐ Yes ☐ No
Chest Pain ☐ Yes ☐ No	Heart Surgery ☐ Yes ☐ No	Organ Transplant ☐ Yes ☐ No	Swollen Ankles ☐ Yes ☐ No
Cold Sores/Fever/Blisters ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Congenital Heart Defects ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Persistent Cough ☐ Yes ☐ No	Tuberculosis (TB) ☐ Yes ☐ No
Difficulty Breathing ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
	High Blood Pressure ☐ Yes ☐ No	Radiation Treatment ☐ Yes ☐ No	Weight gain/loss >10 lbs. ☐ Yes ☐ No

Have you ever had another condition not listed above? ☐ Yes ☐ No *If yes:*

Additional Health Questions

Do you have persistent swollen glands in the neck? ☐ Yes ☐ No		Do you use more than 2 pillows to sleep? ☐ Yes ☐ No	
Do you have chest pain upon exertion or when exercising? ☐ Yes ☐ No		*If yes, why?*	
Are you short of breath after mild exercise or when lying down? ☐ Yes ☐ No		Are you on special diet? ☐ Yes ☐ No	
Do you wake up from sleep short of breath? ☐ Yes ☐ No		*If yes, why?*	

Allergies

Acetaminophen	Yes No	Codeine	Yes No	Jewelry/Metals	Yes No	Sulfa Drugs	Yes No
Amoxicillin	Yes No	Dental Anesthetics	Yes No	Latex	Yes No	Tetracycline	Yes No
Aspirin	Yes No	Erythromycin	Yes No	Penicillin	Yes No		
Barbiturates	Yes No	Ibuprofen	Yes No	Sedatives	Yes No		

Do you have another allergy not listed above? Yes No *If yes:*

Medications *Are you taking any of the following?*

Antibiotics	Yes No	Blood Thinners	Yes No	Insulin/Diabetes	Yes No	Steroids/Cortisone	Yes No
Antihistamines	Yes No	Blood Pressure	Yes No	Medicine		Thyroid Medicine	Yes No
Aspirin	Yes No	Medicine		Nitroglycerin	Yes No	Vitamins and/or	
Birth Control		Digitalis/Heart		Over-the-Counte		Minerals	Yes No
Medication	Yes No	Medicine	Yes No	Medicine	Yes No		
		Herbal Supplements	Yes No	Sedatives	Yes No		

If YES to taking any of the above, please list the name(s) of the medication(s)

Other Personal History

Are you hearing impaired?	Yes No	Do you drink alcohol?	Yes No *If yes, how often?*
Are you wearing contact lenses?	Yes No	Do you use tobacco products?	Yes No *If yes, how often?*
Are you employed in a situation which exposes you regularly to x-rays or ionizing radiation?	Yes No	Are you interested in quitting tobacco?	Yes No
**WOMEN only* : Are you… currently pregnant?	Yes No	trying to get pregnant?	Yes No
currently nursing?	Yes No	using contraceptives?	Yes No

Dentist Information *Please provide your DENTIST and/or dental care facility information*

Physician's Name:	Street Address:
Phone Number:	City, State, & Zip Code:

Dental History

Reason for visit:	Do you require antibiotics before dental treatment? Yes No
When was you last dental appointment?	Have you had a bad experience in the dental office? Yes No
Rate your current dental health: Good Fair Poor	Does dental treatment make you nervous? Yes No
Are you currently under the care of a dentist? Yes No	If yes, circle to what extend: Slightly Moderate Extremely

Oral Hygiene Information

Do you use the following?		How often do you brush your teeth?	**Risk Factors**
Toothbrush	Yes No	How often do you floss your teeth?	**Social economic Statu** Select One
Toothpaste	Yes No	What type of toothpaste do you use?	
Dental Floss	Yes No	What type of toothbrush do you use?	**Education** Select One
Mouth rinse	Yes No	Soft Medium Hard	
Fluoride	Yes No	Are you wearing any dental appliances? Yes No	Any Nutritional Concerns? Yes No
Other Dental Products	Yes No		Any Aging Concerns? Yes No
			Any Immune/Systemic Concerns? Yes No
Do you have any of these oral habits?		Thumb sucking: Yes No	*If YES, please explain:*
		Nail biting: Yes No	
		Clenching: Yes No	
		Grinding: Yes No	

Current & Past Dental Conditions *Do you have or have had any of the following?*

Abscess (oral infection)	Yes No	Difficulty opening or	Yes No	Jaw Surgery	Yes No
Bad breath/unpleasant taste	Yes No	Closing jaw		Loose teeth or broken	Yes No
Blisters on lips or mouth	Yes No	Gums swollen or tender	Yes No	fillings	
Bleeding, sore gums	Yes No	Endodontic (root carnal)	Yes No	Orthodontic treatment	Yes No
Clicking/popping jaw	Yes No	treatment		Periodontal (gum) treatment	Yes No
Dental Implants	Yes No	Extractions	Yes No	Sensitivity to cold,hot,sweets	Yes No

I certify, to the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes, in my health, or medications, I will inform this dental health care provider prior to or at the next appointment without fail.

Signature of Patient, Parent or Guardian:	Date
Student Clinician's Initials	Date

Department of Dental Hygiene

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgment

I have had the opportunity to read this facility's *Notice of Privacy Practices* . I acknowledge I may request and receive a copy of this facility's *Notice of Privacy Practices* as required by law.

Patient's Name: _____ Date: _____

Patient (or Representative) Signature: _____

For Office Use ONLY

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices* , but acknowledgement could not be obtain because: ☐ Individual refused to sign ☐ Other (*please specify*): _____

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Authorization: I , _____ (*print patient's name*), hereby authorize Clayton State University Dental Hygiene Clinic to release, use, and/or disclose my protected health information as directed below.

Health Information: This authorization pertains the following types of protected health information about me:

(***initial each***)

_____ Dental records received or created by this facility

_____ Dental radiographs (x-rays)

_____ Dental intraoral pictures

_____ Other (*please describe if known*) _____

Email address provided to discuss patient notes and/or history:

_____

Release Information: I understand that, per my voluntary request, this Authorization permits Clayton State University Dental Hygiene Clinic to release, use or disclose my protected health information for:

A. Treatment by another health care provider, which includes a) providing, coordinating and managing health care and related services, b) consultation, and c) referral(s); and

B. Purposes other than payment, treatment, or healthcare operations, as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its corresponding regulations.

I further understand that I may revoke this Authorization at any time by providing written notification. Revocation of this Authorization will be effective on the date notice is received and processed by this facility except to the extent that action has already been taken. Please release, upon request, my health information to the following non-health care entities:

Other: _____ Other: _____

(Name of spouse, family member, friend, etc.) *(Name of spouse, family member, friend, etc.)*

Your Rights: Your decision to sign this Authorization is voluntary. Clayton State University Dental Hygiene Clinic will not refuse treatment to you if you refuse to sign this Authorization.

When your protected health information is releases as provided by this Authorization, please be aware that the named recipient(s) above may not be legally obligated (under HIPAA) to obtain an authorization for subsequent re-disclosure of your protected health information.

Patient's Signature: I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this Authorization, I am permitting Clayton State University Dental Hygiene Clinic to release, use or disclose my protected health information.

Patient's Signature: _____ Date: _____

Representative's Signature: I affirm that I am the personal representative of the patient noted above and that I have the authority to authorize the release, use or disclosure of the patient's proteced health information on his/her behalf. I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing. on behalf of the patient, the release, use or disclosure of the patient's protected health information.

Representative' Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

Department of Dental Hygiene

POLICY STATEMENT/RELEASE AND WAIVER OF LIABILITY FORM

AVAILABLE DENTAL HYGIENE HEALTH CARE SERVICES

• Medical and dental history and recording of vital signs
• Extraoral and intraoral examination and recording of all abnormal conditions observed.
• X-rays of the teeth and surrounding jaw bone. Copies of x-rays can be emailed to the patient's dentist, upon request.
Fees may apply for printable copy ($10).
• Dietary analysis and nutritional counseling.
• Fluoride treatment and application of desensitizing agents to the roots of teeth.
• Pit and fissure sealants.
• Scaling and planing of the teeth and local anesthesia as needed.
• Whitening impressions, tray, and material.
• Referral for correction of dental needs to general dentists or dental specialists.
• Referral to physicians for further evaluation or treatment of observed medical conditions.

PATIENT'S RIGHTS AND PATIENT'S RESPONSABILITIES

The prospective patient, when accepted for treatment, will have the following rights:

• Considerate, respectful, and confidential treatment.
• Continuity and completion of treatment during the academic semester in which started or the following academic semester.
• Access to complete and current information about his/her condition.
• Informed consent. All procedures and treatments that are indicated for a particular patient will be explained to the patient before these procedures are performed. Also explained will be treatment alternatives, the option to refuse treatment, the risk of no treatment, and expected outcomes of various treatments available.
• Treatment that meets the standard of care in the dental hygiene profession, as practiced in an academic setting, under the supervision of licensed hygienists or dentists. This includes compliance with all Centers of Disease Control or American Dental Association guidelines for infection control procedures.
• Patients will not be denied available services based solely on handicapped conditions or infectious diseases.

The patient has the following responsibilities:

• Considerate, respectful, and confidential treatment.
• To fully cooperate with the student hygienist and supervising faculty during all phases of professional care. Any aggressive behavior /discrimination will not be tolerated. These actions or failure to respond to staff instructions related to aggressive behavior may result in dismissal from the clinic and discontinuing treatment and opportunity for future care in the *clinic. (examples of aggressive behavior include but not limited to: physical assault, verbal harassment, abusive language, discriminatory language, sexual language at others, threats, etc.)*
• To maintain proper demeanor essential in a health care facility which simultaneously treats other patients.
• To notify the clinic receptionist of an appointment cancellation 24 hours prior to the appointment time and date. A history with failure to keep 3 (three) appointments will result in patient dismissal for a 1 (one) year period. After one (1) year dismissal, if the patient fails to show to an scheduled appointment, a Dismissal Letter from our Dental Hygiene Clinic will be issued and mailed/emailed to the patient.
• If patient fails to show for an appointment and does not give a 24 hour cancellation notice a $10 charge will be added to patient account, and must be paid prior to any future treatment.
• To arrange for child care prior to scheduled appointments. Small children are not allowed unsupervised in the clinic reception area.
• If six months has elapsed since the beginning of treatment:
1. A new fee will be charged and the appointment will be treated as a MUY/MOY (recall);
2. Refunds for uncompleted treatment will not be given.

RELEASE AND WAIVER LIABILITY

The undersigned hereby acknowledges that treatment in the Clayton State University Dental Hygiene clinic involves an inherent risk of physical injury and by the execution of this release hereby assumes all such risks. The undersigned further agrees that for the sole consideration of receiving dental hygiene treatment, the undersigned does hereby release and forever discharge Clayton State University and the Board of Regents of the University System of Georgia, its members, official and individually, and its officers, agents and employees of any and from all claims, demands, rights and causes of action whatever kind and nature, arising from and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries, damages to property, and the consequences thereof, resulting from my participation in or in any way connected with such dental hygiene treatment and/or activities. The undersigned also agrees to review the personal patient record contents to be used anonymously in the education context by the Clayton State University dental hygiene program faculty and students.

I understand that the acceptance of this release and waiver of liability by the Board of Regents of the University System of Georgia shall not constitute nor be construed as a waiver, in whole or in part, of sovereign or official immunity by said Board, its members, officers, agents, and employees.

I certify that I have read and understand this release before signing the same on this the _____ day of_____20_____.

Patient or Guardian Signature

Signed in presence of said Witness (Student Clinician)

Patient copy – yellow / Chart-copy – white

Patient Name

Submit