Patient: Please answer the following questions as completely and accurately as you can.

**Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

 (First) (Last) (MI)

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title (Mr, Ms, Mrs, etc): \_\_\_\_\_\_\_Birthdate: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

Gender: □ Male □ Female □ Other Family status: □ Married □ Single □ Child □ Other

Race: □ American Indian/Alaska Native □ Asian or Pacific Islander □ Black/Non-Hispanic □ Hispanic □ White/Non-Hispanic □ Middle Eastern □ Other □ Prefer not to answer

Addressed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Cell phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_

Email (print clearly): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information**

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Medical Information**

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_

Date of last physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you in good health? (yes/no): \_\_\_\_\_\_\_\_\_\_\_

Are you under the care of your physician? (yes/no): \_\_\_\_\_\_\_\_ if yes describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Questions**

|  |  |
| --- | --- |
| Have you had any serious illness, operation, or been hospitalized in the past 5 years?  If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Yes □ No |
| Are you allergic or had any reactions to medications, drugs, local anesthetics, or other substances? If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Yes □ No |
| **WOMEN**: Are you pregnant or think you may be pregnant? | □ Yes □ No |

**Medical Information**. Check the disease, condition, and/or treatment that you have now or have had in the past.

|  |  |  |
| --- | --- | --- |
| □ AIDS/HIV | □ Allergies | □ Anemia |
| □ Angina/Chest pain | □ Anxiety | □ Artificial Joint |
| □ Arthritis | □ Asthma | □ Bisphosphonate Tx |
| □ Bleeding disorder | □ Cancer | □ Cardiovascular Disease |
| □ Chemotherapy | □ Chronic Cough | □ Congenital Heart Disease |
| □ Diabetes | □ Eating Disorder | □ Emphysema |
| □ Epilepsy/Seizures | □ Fainting/Dizziness | □ Fever Blisters/Cold Sores/Herpes |
| □ Gastric Reflux | □ Glaucoma | □ Heart Disease |
| □ Heart Murmur | □ Heart Pacemaker | □ Hepatitis/Jaundice/Liver Disease |
| □ Hiatal Hernia | □ High/Low Blood Pressure | □ Indwelling Vein Catheter |
| □ Infective Endocarditis | □ Kidney/Renal Disease | □ Mental/Emotional Impairment |
| □ Mitral Valve Prolapse | □ Organ Transplant | □ Osteonecrosis of the Jaw |
| □ Pain in Jaw Joints | □ Physical Impairment (vision, hearing)  | □ Prosthetic Implant |
| □ Respiratory | □ STD/VD | □ Stroke/TIA |
| □ Swollen Glands | □ Tuberculosis – Active | □ Unexplained Weight Change |
| □ Ulcers | □ Yellow Jaundice |  |
| □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ None |  |

Explain all checked responses here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Dental Information.** Check the disease, condition, and/or treatment that you have now or have had in the past.

|  |  |
| --- | --- |
| How long has it been since you have seen a dentist?  □ 6 mo–1 year □ 1-3 years □ 4-6 years □ 7+years |  |
| How long has it been since you have had your teeth cleaned?  □ 6 mo–1 year □ 1-3 years □ 4-6 years □ 7+years |  |
| What is your chief dental complaint? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| What are your sources of drinking water? □ Bottle water □ Well water □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Do you expect to keep your teeth all your life? | □ Yes □ No |
| Do you chew or suck on hard candy, cough drops or mints or chew gum? | □ Yes □ No |
| Are you nervous about dental work or have had a bad experience with dental work?  | □ Yes □ No |
| Do you play contact sports that require you to use a sports mouth guard? | □ Yes □ No |
| Do you use tobacco? Number of years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you interested in quitting?  | □ Yes □ No□ Yes □ No |
| Do you drink alcohol? | □ Yes □ No |

**Patient Medication Information.** Please list all medications you take with dosage and frequency.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the dentist, dental hygiene faculty, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

**Patient Signature** (if over the age of 18 and legally permitted to make health care decisions)

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient personal representative/Parent/Legal Guardian:** I certify that I have the legal authority under federal and state laws to sign this form on behalf of the patient identified below.

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Internal Dental Clinic Use Only

□ Form signed by patient, parent, legal guardian, or personal representative.

 Witness Student Initials \_\_\_\_\_\_\_\_\_\_\_

**Patient Communication Consent**

As pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rule, I consent to the following forms of communication.

□ Cell Phone

□ Home Phone

□ Text Messaging on cell phone: *patient is responsible for any messaging data rates that apply.*

□ Email

**Patient**

* HIPAA permits the Dallas College dental hygiene clinic to leave appointment reminders on answering machines and voicemail systems if you have consented to be contacted by phone. All messages will be limited to appointment specific information only.
* Dallas College will input your consented forms of communication into your electronic record and only contact you via the indicated forms of communication above.
* You reserve the right to change your communication consent preference at any time. A new form with your signature/date is needed prior to Dallas College making the change.

**Patient Signature** (if over the age of 18 and legally permitted to make health care decisions)

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient personal representative/Parent/Legal Guardian:** I certify that I have the legal authority under federal and state laws to sign this form on behalf of the patient identified below.

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Questions?** Please contact the Dallas College HIPAA Privacy Official Lisa Mayo, Academic Chair Dental Hygiene (214) 860-2375 Revised 7.20.23

**Consent for Treatment**

I, the undersigned, understand and consent to the following treatment at the Dallas College dental hygiene clinic:

* **Evaluation**: Screening of my oral health including oral cancer and periodontal assessment, examination by a licensed dentist to provide an overview of my oral conditions and pathology, referrals for dental treatment beyond the scope of the dental hygiene program, and a review of my medical, dental, and social history.
* **Radiological**: X-rays will be taken as part of the patient appointment as they are an integral part of oral health evaluation, diagnosis, and treatment planning. I understand I will not be accepted as a patient without consent for x-rays. If I provide current x-rays from my dental office that are of diagnostic quality, then this can be substituted for the x-rays the Dallas College dentist recommends. If the recommended x-rays are not included in the provided x-rays from my dental office, I will allow the clinic to take the missing x-rays.
* **Treatment**: I consent to allowing a student hygienist to perform all diagnosed dental hygiene procedures. All student hygienists work under the direct supervision of a licensed dental hygienist and dentist and all steps of appointments are evaluated by these licensed individuals.
* **Excluded Treatment**: I understand the Dallas College dental hygiene clinic only provides dental hygiene preventive services and any dental treatment needs I have beyond dental hygiene services will be referred to an outside the college dental provider. I understand regular visits with a dentist is needed for optimal oral health.
* **Appointments**: Multiple appointments will be needed to complete my treatment as the Dallas College dental hygiene clinic is a teaching institution. I agree to attend all scheduled appointments for the length of time they are scheduled. Failure to comply with appointment standards may result in my dismissal from the dental hygiene clinic.

**Patient Signature** (if over the age of 18 and legally permitted to make health care decisions)

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient personal representative/Parent/Legal Guardian:** I certify that I have the legal authority under federal and state laws to sign this form on behalf of the patient identified below.

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bloodborne and Infectious Disease Policy**

Dallas College publishes the College [Communicable Disease Policy](https://pol.tasb.org/Policy/Download/358?filename=FFAC(LOCAL).pdf&filename=FFAC(LOCAL).pdf) on the Dallas College Website In addition to the Dallas College policy, the Dental Hygiene Program has adopted additional clarification of this policy for use in the program in conjunction with the recommendations and regulations consistent with of the Occupational Safety and Health Administration (OSHA), the Center for Disease Control (CDC) and related national and state regulatory agencies. The OSHA Bloodborne Pathogens Standard, in its entirety is available at the clinic front desk, it is posted on the current student, staff, and faculty portal, and accessed through the [OSHA Bloodborne Pathogens Standard link](https://www.osha.gov/bloodborne-pathogens). This policy is updated annually or as new information on infectious diseases becomes available.

**Dallas College Dental Hygiene Communicable Disease Policy**

A work hazard of a clinically practicing dental professional treating live patients is the potential to be exposed to communicable diseases and bloodborne pathogens. Standard precautions represent a set of rules healthcare providers follow to protect themselves and their patients from pathogens spread by body fluids. Standard precautions aim to prevent the transmission of communicable and bloodborne pathogens through inhalation, direct contact, indirect contact, and sharps prevention. The dental hygiene program enforces and educates students and employees on healthcare standard precautions so they may safely treat patients and be knowledgeable of disease transmission risk.

**Admission and Patient Treatment**

* The Dental Hygiene Program is non-discriminatory with regards to persons who are seropositive for HIV/AIDS, HBV or other infectious diseases. Having a communicable disease will not exclude a person from admission to the program, employment, patient treatment or access to the college’s services or facilities because of their health status. They will be provided with all reasonable accommodations unless a medically based evaluation determines that exclusion or restriction is necessary for the welfare of the individual, other members of the institution, patients or affiliates (patient care community).
* Applicants/students who believe they are at an increased risk of contracting an infectious disease should seek testing and counseling prior to making application to the Dental Hygiene Program.
* Students who plan to enter the Dallas College dental hygiene program will be required to read and sign a communicable disease statement and waiver of liability form. This form will become a part of the student’s permanent record and will state that the student:
* has been informed of their risk for exposure to blood and body fluids;
* understands the potential transmission of bloodborne disease during patient care activities;
* agrees to undergo testing following an occupational incident or needle stick exposure to bloodborne pathogens or a sign a declination form in the event a student refuses to undergo testing;
* maintains required health insurance and is financially responsible for any expenses incurred from the testing/treatment following an occupational incident and/or communicable disease exposure; and
* agrees to treat all patients that are assigned regardless of disease state presented by the patient. Students who are minors must have the form signed by a parent or legal guardian and the form must be notarized.
* Individuals who know or have a reasonable basis of possible infection with HIV/AIDS, HBV or other infectious diseases are expected to seek expert advice concerning their health circumstances and are obligated legally and ethically to conduct themselves in a responsible and safe manner on campus as a protection to the college community.
* The College recognizes the importance of protecting the confidentiality and privacy of any employee/student/patient found to have HIV/AIDS, HBV or other infectious disease. This information will be handled with care and sensitivity and will be kept confidential
* Patients with active infectious diseases will be assigned to the appropriate clinic based on the patient’s medical condition and the experience level of the student. A Dallas College faculty or dental hygiene student may not ethically refuse to treat a patient whose condition is within the dental hygienists’ realm of competence, solely because that patient is at risk of contracting, or has, an infectious disease such as HIV, AIDS or Hepatitis B infection. These patients must not be subjected to discrimination.
* Patients with medical/dental needs beyond the scope available in the dental hygiene clinic will be referred to an appropriate agency. Patients will be responsible for all costs incurred resulting from a referral.
* Patients must sign a consent form contains the following information: “I understand that in the event a Dallas College employee or student is exposed to my blood and/or body fluids. I agree to undergo testing for blood pathogens (Hepatitis B, HIV/AIDS). I also agree to have the testing agency report the results of my test to the Dental Hygiene Director at Dallas College. I realize that the College recognizes the importance of confidentiality and will only release my test results to those persons having a need to know. I understand I must seek the services of a health care provider for testing purposes, and I will be responsible for all costs incurred from such services.” Patients will be given the right to decline testing.

 **Students**

* Students in the School of Health Sciences must be able to prove immunity to mumps, measles, rubella, tetanus, diphtheria, polio and varicella zoster, hepatitis B and tuberculosis. Annual TB testing is required.
* No student will be allowed to deliver patient care in any setting until he/she has been instructed in infection control and has mastered material on safety/standard precautions with satisfactory accuracy. Students will be expected to care for patients with health deviations including patients with HIV/AIDS, HBV, HCV, and other bloodborne infectious diseases as part of routine clinical/laboratory curriculum experiences, following mastery of infection control skills and under faculty supervision.
* Engineering controls are in place to eliminate or minimizing student/employee exposure to include the use of shielded needle devices. Best practices to prevent sharps and needlestick injuries include: bloodborne pathogens training, proper needle and sharps handling, and immediately disposing contaminated needles in approved, labeled sharps containers.
* If a Dallas College employee or student is intentionally or unintentionally exposed to body fluids, bloodborne pathogen, or communicable disease through treatment rendered, both the individual and the source patient should be tested. The cost for testing rests with the patient and the exposed individual.

**Management of Herpetic Lesions and Tuberculosis:**

* **Herpetic Lesions:** If a patient has an active herpetic lesion (small blisters that are filled with a clear or yellowish fluid and may appear red around the edges) treatment must be postponed until the lesion is fully scabbed or healed.
* **Tuberculosis:** Although the risk of transmission of tuberculosis in dental settings is low, the Centers for Disease Control and Prevention (CDC) recommends dental health care personnel (DHCP) include protocols for TB infection control in their offices’ written infection control program.
	+ - *Latent Tuberculosis (TB)* is caused by infection with the bacterium Mycobacterium tuberculosis and can live in the lungs of an infected person for years, even a lifetime, without the person exhibiting any symptoms. A person with latent TB is not infectious to others and generally has no symptoms.
		- *Active TB* can be transmitted and is generally accompanied by symptoms such as a productive cough, fever, fatigue, pain in chest, or weight loss. The Centers for Disease Control and Prevention (CDC) has developed guidelines for preventing transmission of Mycobacterium tuberculosis in health-care settings, which the Dallas College Dental Hygiene Program follows. The first step is by conducting a Medical History. The patient demonstrating signs or symptoms of active TB will be dismissed from the clinic immediately and referred to their medical provider.

**Patient Signature** (if over the age of 18 and legally permitted to make health care decisions)

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient personal representative/Parent/Legal Guardian:** I certify that I have the legal authority under federal and state laws to sign this form on behalf of the patient identified below.

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Bill of Rights**

Dallas College dental hygiene clinic is a teaching institution. All patients will receive high quality dental hygiene services at no charge if their treatment needs are within the scope of practice for the dental hygiene clinic and there is a student need. Student hygienists provide direct patient care under the direct supervision of a licensed dental hygienist and dentist.

**Services Available**

|  |  |  |
| --- | --- | --- |
| * Medical/Dental/Social History review
* Vital signs
* Oral Cancer Screening
* Radiographs (X-rays)
* Cleanings
* Deep cleanings
 | * Oral Health Education
* Periodontal Assessment
* Fluoride
* Application Desensitizing Agents
* Sealants
* Teeth Whitening
 | * Care of Dental Prosthesis
* Nutritional Counseling
* Smoking Cessation
* Injectable and Non-Injectable Local Anesthesia
 |

**\*Fees** All above services are provided at no charge except for Teeth Whitening.

**Patient’s Bill of Rights**

The students, faculty and staff of the Dallas College Dental Hygiene Program strive to provide each patient with a high quality of care. As our patient, you are entitled to:

1. considerate, respectful and confidential treatment;
2. continuity and completion of treatment;
3. access to complete and current information about his/her condition;
4. advance knowledge of the cost of treatment;
5. informed consent;
6. explanation of recommended treatment, treatment alternatives, the option to refuse treatment the risk of no treatment, and expected outcomes of various treatments;
7. treatment that meets the standard of care in the profession.

**Expectations for Patients**

Patient: Please read through the below information and sign the bottom of the form if you agree to the patient rights and expectations listed.

* **Appointments**: I will be on-time and attend all scheduled appointments for the length of time they are scheduled. I will attend multiple appointments needed to complete my treatment. I will provide **24-hours**’ notice if I need to reschedule my appointment.
	+ **Minors**: I understand that minor children (under 18) cannot be left unattended without a legal guardian. Children are only allowed in the clinical area unless they are a patient. Parents/guardians presenting with unattended minor children will be dismissed. Children under three years of age may not be mature enough for clinical care, and a referral to a children's specialist (Pediatric Dentist) may be required.
* **Medical Consultation**: I understand that a medical consultation from my health care provider may be needed prior to receiving treatment at the dental hygiene clinic. This decision will be made during my appointment.
* **Behavior**: I will be respectful and considerate of all Dallas College dental hygiene employees and students. I understand this is a teaching institution and that students may need more time to render services than a private practice licensed provider. Any unbecoming behavior will result in my dismissal as a patient from the dental hygiene clinic and I will be provided a referral with a list of dental providers who can continue my treatment.
* **Dental Home**: I understand that care received in the dental hygiene clinic does not replace the need for an annual dental examination with a licensed dentist or community dental clinic. Being a patient in the dental hygiene clinic does not guarantee extended or ongoing dental hygiene services.

Thank you for your contribution to our student learning. Your attendance is valuable, and we appreciate your support. Please do not provide gifts to Dallas College employees or students.

**Patient Signature** (if over the age of 18 and legally permitted to make health care decisions)

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient personal representative/Parent/Legal Guardian:** I certify that I have the legal authority under federal and state laws to sign this form on behalf of the patient identified below.

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Practices (NPP)**

This notice describes how patient health information is used and disclosed by the Dallas College dental hygiene clinic and how a patient can gain access to this information. Please review and read carefully.

The Dallas College dental hygiene clinic is required by law (Health Insurance Portability and Accountability Act and Texas HB300) to maintain the privacy of patient protected health information (PHI), to provide notice with our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this NPP while it is in effect. This NPP takes effect on July 20, 2023, and will remain in effect until it is replaced at a future date.

The Dallas College dental hygiene clinic reserves the right to change the NPP and the terms of the NPP at any time, provided such changes are permitted by federal and state laws, and to make new NPP provisions effective for all PHI that we maintain. When a change to the NPP occurs, we will change the postings in the clinic, provide a copy to any patient who requests it, and change our NPP on the dental hygiene clinic website.

You may request a copy of this NPP at any time and will be provided a copy the same day. You will be asked to sign this NPP on your first appointment and your signed document will be good for **6 years**. This form is compliant with **HIPAA and Texas Health & Safety Code 181.001**.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose your health information for different purposes, including treatment and health care operations. For each of these categories, we have provided a description and example. Some information, such as HIV-related information, genetic information, alcohol/substance use/abuse, and mental health records may be entitled to special confidentiality protection under applicable federal or state law. We abide by these special protections as they pertain to applicable cases.

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| **Treatment**We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist proving your treatment.**Healthcare Operations**We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assurance and improvement activities, conducting training programs, and licensing activities. Patient identifiable data is not used in these operations.**Individuals Involved in Your Care**We may disclose your health information to your family or friends, patient representative, or any other individual identified by you when they are involved in your care. If a person has the authority by law to make health decision for you, we will treat that patient representative the same way we would treat you with respect to your health information.**Disaster Relief**We may use or disclose your health information to assist in disaster relief efforts.**Required by Law**We may use or disclose your health information when we are required to do so by law.**National Security**We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official’s health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of the PHI of an inmate or patient.**Secretary of HHS**We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.**Coroners, Medical Examiners, Funeral Directors**We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties. | **Public Health Activities**We may disclose your health information for public health activities, including disclosures to: Prevent or control disease, injury, or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of products or devices; Notify a person who may have been exposed to a disease or condition; Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.**Workers Compensation**We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs established by law.**Law Enforcement**We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.**Health Oversight Activities**We may disclose PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.**Judicial and Administrative Proceedings**If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made by either the requesting party or us to tell you about the request or to obtain an order protecting the information requested.**Research**We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your information. If private patient information would be used in the research, this is only done upon patient written consent.  |
| **YOUR HEALTH INFORMATION RIGHTS** **Access**You have the right to look at or obtain copies of your health information with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this NPP. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you requested if readily producible. We do not charge for this service. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.**Disclosure Accounting**With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing. **Right to Request a Restriction**You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both, (3) to who you want the limits to apply. We are not required to agree to your request.**Alternative Communication**You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location. We will accommodate all reasonable requests. Requests that would endanger or increase the risk to an employee or student will not be approved. Requests that violate Dallas College policies will not be approved.**Amendment**You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you as such. If we deny your request for an amendment, we will provide you with a written explanation of the denial and your rights.**Right to Notification of a Breach**You will receive notification of a breach to your unsecured PHI as required by HIPAA law.**Electronic Notice**You will receive a paper copy of this NPP upon your request even if you have agreed to receive this NPP electronically. | **OTHER USES AND DISCLOSURES OF PHI**Your authorization is required by HIPPA, with few exceptions, for disclosure of psychotherapy notes, use of disclosure of PHI for marketing and fundraising, and for the sale of PHI. Dallas College does not participate in the marketing, fundraising, or sale activities that would require the release of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for use in this NPP (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we still stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.**QUESTIONS AND COMPLAINTS**If you want more information about our privacy practices or have questions or concerns, please contact us.If you are concerned we have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communication with you by alternative means or at alternative locations, you may complain using the contact information listed at the end of this NPP. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon your request.We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services |

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Patient Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient, Legal guardian, or Personal representative signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (circle one): Self Parent/Guardian Personal Representative

Internal Dental Clinic Use Only

□ Form signed by patient, legal guardian, personal rep. □ Form signature refused. I explained the NPP and attempted to obtain a signature. The reason provided for the rejection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student initials \_\_\_\_\_\_\_\_\_

**Questions?** Please contact the Dallas College HIPAA Privacy Official Lisa Mayo, Academic Chair Dental Hygiene (214) 860-2375 Revised 7.20.23