FOOTHILL COLLEGE DENTAL HYGIENE PROGRAM
PATIENT GENERAL INFORMATION

SUPERVISION TIME

The Foothill College Dental Hygiene Clinic provides patient services under the supervision of a licensed dentist and registered dental hygiene instructors, as a learning experience for the students participating in the Dental Hygiene Program. Because services are performed by students, your appointment will demand more time than in a private dental office. You will receive thorough and complete care as instructors evaluate all procedures, with support documentation for your particular dental hygiene needs. Student operators receive a grade for each appointment.

APPOINTMENT PROCEDURES

- Your first appointment will be a ***limited examination appointment*** approximately for 1 hour. A thorough health/dental history and a limited soft/hard tissue exam will be performed at this time. If dental x-rays are necessary for proper treatment, they may also be taken at this appointment; or if available, please bring your x-rays with you. At the end of the examination appointment you will be advised of your treatment needs, approximate number of appointments and fees. You will then be reappointed with a student operator for your care.
- Expect to have ***at least 2 to 4 appointments or more*** and ***each appointment is typically 3 to 4 hours*** depending upon your treatment needs and the students' educational level in the two year Dental Hygiene Program.

REFERRAL

Our clinic ***does not provide*** restorative dentistry (fillings), oral surgery, periodontal surgery or orthodontics. You will be referred to your own private dentist for follow-up care. If you do not have a dentist, the directory of community dental resources will be given to you upon completion of treatment.

X-RAYS

Dental X-rays will be taken as necessary and as appropriate for dental hygiene assessments, dental examinations, diagnosis, consultation, and treatment. In certain cases, treatment in the Foothill College Dental Hygiene Clinic ***will be refused without current x-rays present.***

MEDICALLY COMPROMISED PATIENTS

Patients with a medical or dental condition that precludes proper treatment may not be acceptable to our clinic facility. The initial examination appointment will identify conditions which may warrant referral to a medical doctor or a dentist. Please bring a list of all current medications. The following are conditions of patient acceptability for treatment in the Dental Hygiene Clinic:

1. Free from any medical or dental condition that would make treatment hazardous to patient or operator.
2. Oral conditions are considered acceptable for student learning.
3. Patient interest in learning preventive oral hygiene techniques.
4. Patient cooperation in keeping all clinic appointments ***on time***.

NOTE: The clinic supervisor reserves the right *at* any time to refuse or discontinue treatment when indicated.

KEEPING YOUR APPOINTMENTS & OUR CANCELLATION POLICY

Patients are required to be on time for their appointments. If cancellation of your appointment is necessary, **24 hours advanced notice within Monday through Friday campus week** is required to allow your student adequate time to refill the empty appointment time. The student's final grade is based on the number of patients completed. A total of TWO cancellations without 24 hours notice, TWO missed appointments, or repeated unsuccessful attempts to arrange for an appointment may be cause to discontinue a patient from further treatment in the Dental Hygiene Clinic.

MINORS - UNDER AGE 18: Children under three years of age must be mature enough for clinical care. All children must be accompanied by a parent or legal guardian, who ***must*** **remain in the clinical facility during patient care**. A consent form for treatment must be signed by parent or legal guardian before treatment is rendered for children under 18 years of age.

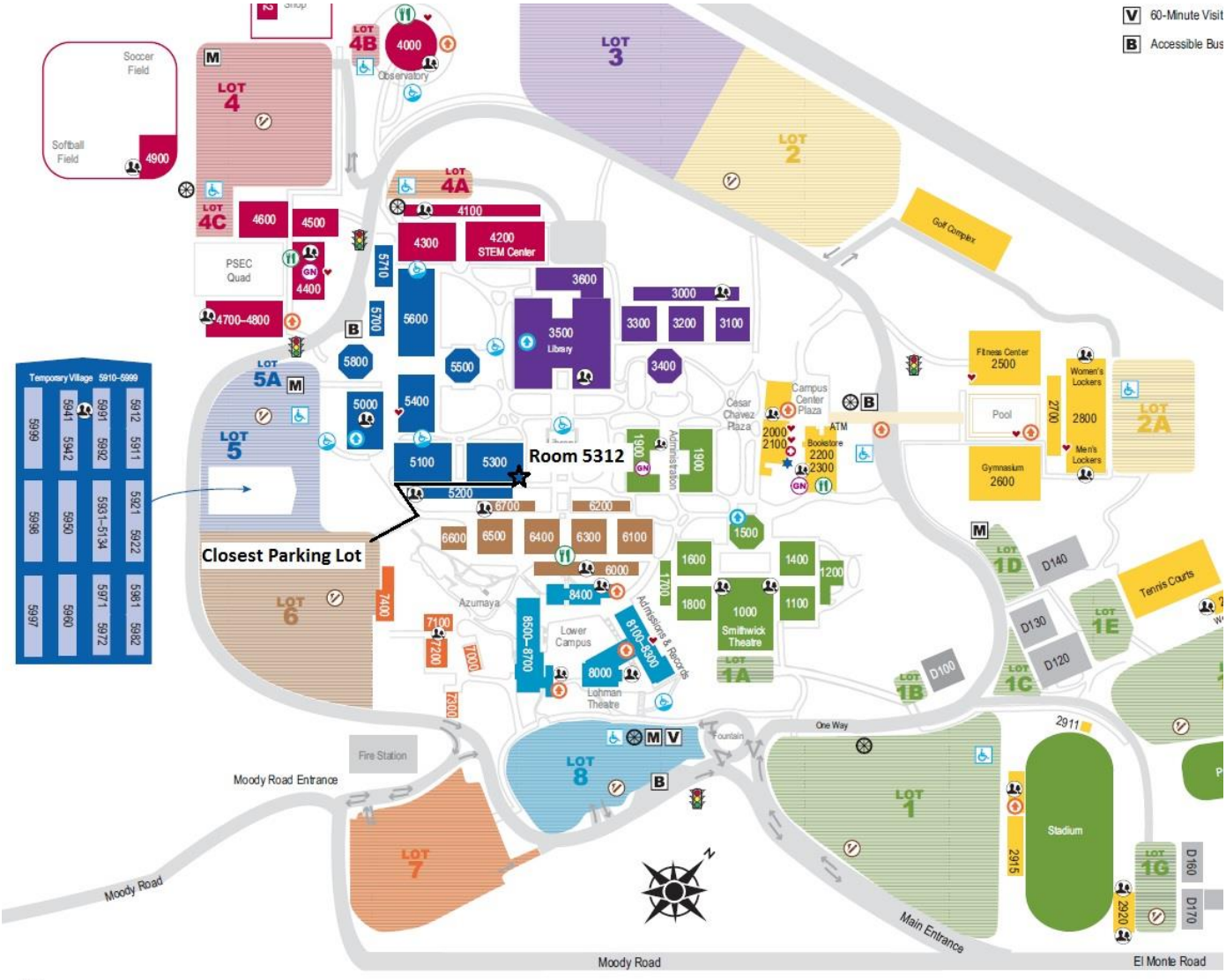
FEES: Payment is due at the time of service and is payable by **cash or check only**. Denti-Cal, credit, debit card or insurance cards are not accepted. All fees are subject to change without notice. Foothill students can get free teeth cleaning and x-rays if the student body fee is paid off for the current quarter. Note: Medi-Cal patients get a 50% adjusment for the teeth cleaning but no adjustment for x-rays.

Teeth Cleaning	$30.00	Bitewing X-Rays	$20.00
Full Mouth X-Rays	$40.00	Periapical (Single film)	$5.00
Panoramic	$25.00	ITR per tooth	$5.00

CLINIC HOURS Call **(650) 949-7335** to schedule for the appointment
9:00AM – 12:00PM (Monday, Wednesday, Thursday)
1:30PM – 4:30PM (Tuesday)
Our hours may vary from quarter to quarter. The clinic is closed during Winter break, Spring break, Summer break and other College holidays.

Foothill College Directions, Parking & Campus Map

- Address: 12345 El Monte Rd, ***Building 5300/ Room 5312***, Los Altos Hills, CA 94022
- From Interstate 280, take West El Monte Road exit. Foothill College is on the right about 100 yards west of the freeway. The road around the campus is now *one-way*.
- Clinic parking is available in ***all the student lots. Parking lots 5 and 6 are closest to the Dental Clinic; however, parking lot 5 is only for staff and disabled persons with handicapped placards.***
- One-day parking permits are available for $3.00 (25¢ and $1 dollar bill), in the yellow machines located on the light posts in each parking lot; additionally, we do have free parking permits available in the clinic.



FOOTHILL COLLEGE DENTAL HYGIENE PROGRAM
MEDICAL HISTORY

(Please Answer All Questions in Ink)

Patient's Name:_____ D.O.B: _____ Sex: ☐ M ☐ F
(First) (Middle) (Last)

Home Address: _____City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Email: _____

Dentist's Name: _____ Phone: (_____)_____

Address: _____City: _____ State: _____ Zip Code: _____

Physician's Name: _____ Phone: (_____)_____

Address: _____City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone: (_____)_____ Relationship:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes	☐ No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	_____
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	_____
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	_____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	_____
Are you on a special diet?	☐ Yes	☐ No	_____
Do you use tobacco?	☐ Yes	☐ No	_____
Do you use controlled substances?	☐ Yes	☐ No	_____

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Taking oral contraceptives? ☐ Nursing?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs Other _____

Please check (✓) any of the following that apply to you:

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No
If yes, please explain:_____

Comments: _____

_____

TURN FORM OVER AND ANSWER QUESTIONS ON THE BACK

DENTAL HISTORY

General Dental Care:

What is your main dental concern? _____

Do you have any dental pain at this moment? ☐ Yes ☐ No

Do you have any implants, white fillings, bonding or veneers in your mouth? ☐ Yes ☐ No

Date of last dental visit: _____ Date of last teeth cleaning: _____

Date of last dental X-rays: _____ Type of survey? ☐ Bitewing ☐ Full Mouth X-ray ☐ Panoramic X-ray

How often do you brush? _____ How often do you floss? _____

Type of toothpaste you use: _____ Type of mouthwash you use/how often? _____

History:

Are your teeth sensitive to:

Hot or Cold?	☐ Yes	☐ No
Biting/Chewing?	☐ Yes	☐ No
Sweets	☐ Yes	☐ No

Have you ever had:

Orthodontic Treatment?	☐ Yes	☐ No
A Bite Plate or Guard?	☐ Yes	☐ No
Periodontic Treatment?	☐ Yes	☐ No
Oral Surgery?	☐ Yes	☐ No
Serious Injury to Mouth or Head	☐ Yes	☐ No

Habits:

Grind Teeth?	☐ Yes	☐ No
Bite Cheek?	☐ Yes	☐ No
Tongue Thrust?	☐ Yes	☐ No
Mouth Breather?	☐ Yes	☐ No
Bulimia/Anorexia?	☐ Yes	☐ No
Cigar/ Cigarette?	☐ Yes	☐ No
Pipe?	☐ Yes	☐ No
Bite Nails?	☐ Yes	☐ No

Smokeless Tobacco?	☐ Yes	☐ No
Thumb/Finger?	☐ Yes	☐ No
Toothpick/Stimulator?	☐ Yes	☐ No
Chewing Gum?	☐ Yes	☐ No
Candy?	☐ Yes	☐ No
Soft Drinks	☐ Yes	☐ No

Other: _____

To the best of my knowledge, all of the preceding answers are true and correct. I understand that it is my responsibility to inform the Foothill College Dental Hygiene Program if I, or my minor child, ever have any changes in the above information. I will not hold faculty, students or any staff members responsible for any errors or omissions that I may have made in completion of this form.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please Print Name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Rev.11/2014/tn

FOOTHILL COLLEGE DENTAL HYGIENE PROGRAM

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (April 14, 2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

PLEASE TURN FORM OVER AND SIGN ON THE BACK

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you for each page, and per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or 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 communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may 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 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 with the U.S. Department of Health and Human Services.

Contact: Foothill College Dental Hygiene Program
12345 El Monte Rd, Los Altos Hills, CA 94022
Telephone: (650) 949-7335 Fax: (650) 947-9788

Your signature on this form certifies that you have read and understand this Notice of Privacy Practices.

Signature _____ Date _____

Print Name _____ If signed by other than the patient, indicate relationship: _____
(i.e. parent/guardian/conservator)

For Office Use Only

☐ Patient was informed of this Notice of Privacy Practices but patient refused to sign.

Rev. 11/2014

FOOTHILL COLLEGE DENTAL HYGIENE CLINIC
CONDITIONS OF TREATMENT AND CONSENT FORM

GENERAL INFORMATION: Foothill College Dental Hygiene Clinic is primarily a teaching clinic, and therefore patients receiving dental hygiene care will be participating in the teaching program. Patients will be selected only if they are considered suitable as teaching cases. Treatment will be performed by a dental hygiene student and will be supervised by members of the Foothill College faculty. Treatment under supervision generally requires more time than if done in a private practice. For adults, expect to have ***at least 2 to 4 appointments or more and each appointment is typically 3 to 4 hours*** depending on your treatment needs and the students' educational level in the two year Dental Hygiene Program.

The Foothill College Dental Hygiene Clinic is not a substitute for a regular visit to your dentist. Patients are treated in the Dental Hygiene Clinic once a year. It is recommended that all patients seek dental care between visits at Foothill College. In certain cases, treatment in the Dental Hygiene Clinic may be refused until treatment is provided by the patient's dentist.

APPLICATION TO BECOME A PATIENT: Only patients whose care is suitable for teaching purposes are eligible for care in the Foothill College Dental Hygiene Clinic. New patients require an initial evaluation or assessment appointment to determine if they are eligible. Patients are not offered dental hygiene treatment in the Foothill clinic will be referred for treatment to their dentists, to dental school clinical programs, or, if they have no dentist, to the local dental society. 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 the patient will be referred to his/her dentist.

CONSENT TO DENTAL HYGIENE PROCEDURES: Before receiving treatment, you should ask the student hygienist about the procedure(s) that he/she recommends you undergo, and ask any questions you may have before you decide whether to give your consent for the procedure(s) to be done. You have the right to be informed of any risks and complications, the expected benefit, and the availability of alternative methods of treatment. You have the right to consent or to refuse any proposed procedure at any time prior to its performance.

PATIENT ACCEPTABILITY: The following are conditions of patient acceptability for treatment in the Dental Hygiene Clinic:

1. Free from any medical or dental condition which would make treatment hazardous to patient or operator,
2. Oral conditions are considered acceptable for student learning,
3. Patient interest in learning preventive oral hygiene techniques,
4. Patient cooperation in keeping clinic appointments on time,
5. The clinic supervisor reserves the right to refuse or discontinue treatment when indicated.

X-RAYS: Dental X-rays will be taken as necessary and as appropriate for dental hygiene assessments, dental examinations, diagnosis, consultation, and treatment. In certain cases, treatment in the Foothill College Dental Hygiene Clinic will be refused without current x-rays present.

FINANCIAL RESPONSIBILITY: Patients who receive treatment in the Dental Hygiene Clinic will be charged for treatment according to the fee schedule in effect. A fee estimate will be provided prior to beginning treatment and patients must be prepared to pay for services.

DENTAL RECORDS: The records, x-rays, photographs, models, and other materials relating to your treatment in the Dental Hygiene Clinic are the property of the Dental Hygiene Clinic. You have the right to inspect such materials and to request copies. In addition, your dental/medical 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 agree to notify the student dental hygienist or the appointment secretary at least 24 hours in advance. A total of TWO cancellations without 24 hours notice, TWO missed appointments, or repeated unsuccessful attempts to arrange for an appointment may be cause to discontinue a patient from further treatment in the Dental Hygiene Clinic.

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.

Signature _____ Date _____

Print Name _____ If signed by other than the patient, indicate relationship: _____
(i.e. parent/guardian/conservator)

The Foothill College Dental Hygiene clinic does not discriminate against any person in the provision of Dental Hygiene care based on race, color, national or ethnic origin, or age, gender, religion, sexual orientation, marital status or physical/mental disability.

FEDERAL PRIVACY NOTIFICATION: Public Law 93-579, referred to as the Federal Privacy Act, became effective September 27, 1975. Section 7(b) this law requires that any Federal, State, or local government agency which requests an individual to disclose his/her Social Security Number shall inform that individual whether that disclosure is mandatory or voluntary, by what statute or other authority it is solicited and what uses will be made of it.