RSC ALLIED DENTAL

Rose State College Dental Clinic

Personal and Health History- Adult

2025-2026

Please print in black or blue ink and fill in all spaces.

Name:		
(last)	*(middle initial)*	*(first)*
Preferred Name:		Preferred Pronouns:
Gender:	Date of Birth:	Age:
Place of Birth:	Occupation:	
Home Address:		
(street)	*(city)*	*(state, zip code)*
Phone:	Cell Phone:	
Email Address:		
Emergency Contact:	Relationship:	Phone:
Dentist's Name:	Address:	Phone:
Date Last Seen:	Purpose:	Date of Most Recent Dental X-rays:
Physician's Name:	Address:	Phone:
Date Last Seen:	Purpose:	

1. Are you available for multiple and lengthy appointments? Y N (circle one)
2. Are you in good health? Y N
3. Are you currently under the care of a physician? Y N
4. Has there been any change in your general health in the past year? Y N
5. When was your last physical examination?

   _____

6. Have you ever had a serious illness or operation? If so, what was it?

   _____

7. Have you been hospitalized within the past five years? If so, for what?

   _____

8. Are you fearful of dental treatment? On a scale of 1 (completely comfortable) to 10 (very fearful) _____

9. Do you have any food, drug, or other allergies? If so, what are they? _____

   _____

10. What medications are you taking? Include prescription, over the counter, supplements, and cannabis.

_____

_____

_____

Please place a check mark next to each condition you have or have previously been diagnosed with.

11. Damaged or artificial heart valve	32. Sinus problems	52. Emphysema
12. Congenital heart lesion	33. Asthma	53. COPD
13. Heart disease (heart attack, hardening of the arteries, etc.)	34. Cough up blood or tuberculosis	54. Rheumatoid arthritis or other autoimmune condition
14. Infective endocarditis	35. Persistent cough	55. Osteoarthritis (joint pain)
15. Chest pain	36. Stomach ulcers	56. Diabetes
16. Pacemaker	37. Kidney problems	57. Frequent urination
17. Stroke	38. Hepatitis or liver problems	58. Excessive thirst
18. Artificial joints	39. Low blood pressure	59. Dry mouth
19. Shunts	40. High blood pressure	60. Relative w/diabetes
20. Fainting, seizures, or epilepsy	41. Service dog	61. Anemia
21. Thyroid disease	42. Hearing impairment	62. Sickle cell anemia
22. Mental health disorder	43. Vision impairment	63. Had a blood transfusion
23. Frequent headaches	44. Mobility aids (walker, wheelchair, etc.)	64. Blood disorder
24. Cold sores, oral herpes	45. Cerebral palsy	65. Bruise easily
25. Periodontal (gum) disease	46. Developmental disorder	66. Abnormal bleeding after dental or other medical care
26. Sexually transmitted infection	47. Autism spectrum or neurodivergence	67. Serious problems after dental treatment
27. HIV positive status	48. Surgery or radiation of the head or neck	68. Removable denture, partial, or appliance
28. AIDS or other immune system condition	49. Have taken bisphosphonates (Fosamax, Boniva, etc.)	69. Dental implants
29. Cancer		
30. Eating disorder	50. Have taken steroids in the past year	70. Currently pregnant
31. Drug or alcohol dependency	51. Regularly exposed to x-rays due to employment	71. Anticipate becoming pregnant

72. Do you have any other condition not listed above? _____

73. Do you use nicotine products in any form? Y N
If so, what type? _____ How often? _____ For how long? _____

I have completed all forms truthfully and to the best of my knowledge. I will notify the student if any changes occur.

Patient Signature: _____ Date: _____

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Rose State College
Allied Dental Programs
Consent Form

I, _____, hereby consent to receive dental treatment provided by students enrolled in the Allied Dental programs at Rose State College under the supervision of licensed dental professionals. I understand that the purpose of these services is for educational and training purposes.

Treatment Offered: I consent to receive the following treatment as deemed necessary by the supervising faculty and students:
Dental Treatment: In order to provide comprehensive dental hygiene care, students will perform a thorough intraoral and extraoral exam, assessment of the tissues, and clinical evaluation prior to scaling, polishing, and fluoride varnish. As part of your treatment, it may be necessary to take dental impressions. These impressions are essential for accurate diagnosis and planning of your dental care.
_____ **(pt. initial)**

Non-Surgical Periodontal Therapy: Periodontal instrumentation for the treatment of periodontal disease. Depending on the severity, local anesthesia may be necessary to maintain patient comfort and clinician safety.
_____ **(pt. initial)**

Radiographic Examination: X-rays for diagnostic purposes. X-rays are necessary for a thorough oral evaluation of the teeth and supporting structures. **Patients who do not bring or do not consent to a current set of x-rays will not be seen in the RSC clinic.**
_____ **(pt. initial)**

Risks: I understand that there are certain risks associated with dental hygiene procedures, including but not limited to: Potential discomfort or sensitivity during dental cleanings. Rare instances of allergic reactions to dental materials. Minimal exposure to radiation during x-ray procedures.
_____ **(pt. initial)**

Voluntary Consent: I acknowledge that I am consenting to receive dental hygiene services voluntarily and that I have been given the opportunity to ask questions and seek clarification about the nature and purpose of the services. I have read and understood the information provided above, and I consent to receive dental hygiene services at Rose State College as outlined.
_____ **(pt. initial)**

Patient's Signature: _____ Date: _____

Parent/Guardian Consent (if patient is a minor):

I, _____, hereby consent to the dental hygiene services outlined above on behalf of my minor child, _____, and I agree to all terms and conditions stated in this form.

Parent/Guardian's Signature: _____ Date: _____

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Rose State College

Allied Dental Programs

Patient Rights and Responsibilities Form

To Our Patients,

Thank you for coming today!

In order to facilitate the learning process for our students, it is necessary to complete a patient screening before making appointments. The services provided by the Allied Dental Program students, under the direction of licensed dental personnel, do not constitute full dental care and we recommend you consult a dentist regularly for examination, diagnosis, and treatment.

A non-refundable fee of $10.00 (ten dollars) is charged at your initial dental screening appointment per academic year. Only cash or check will be accepted and payment is expected at the time of the initial screening appointment.

After your dental hygiene care is completed, the student will provide you with a Current Dental Status Report to inform you of your overall dental health and the recommended interval until your next dental hygiene care appointment. This report will also provide information regarding your needed dental treatment.

Important Features of Receiving Care at RSC's Dental Hygiene Clinic

1. The RSC dental hygiene clinic is a learning facility and considerably more time is required by a student to perform the dental hygiene services necessary than may be required in a private practice office.
2. To ensure that patients are assigned to students with the appropriate skill level to provide their care, patients must be screened before being assigned to a student.
3. While RSC dental hygiene students strive to schedule patients as soon as possible, there is not a definitive time that can be given as to when you will be contacted for your cleaning.
4. Students are required to fulfill a certain number of hours of clinical instruction in the dental hygiene program. For this reason, it is necessary that patients do not miss or break appointments. If an appointment must be rescheduled, patients must give the students a minimum of a 24-hour notice so that they may contact another patient on their list.

Patient Responsibilities

1) **Keep all scheduled appointments.** If I fail to appear for appointments or do not cancel them with at least a 24-hour notice, I may be dismissed from the clinic_____ **(pt. initial).**
2) **Arrive on time for my appointment AND stay for the entire appointment.** My reserved appointment will only be held for ten minutes. Therefore, if I arrive late, my scheduled appointment may be given to someone else. After more than one late unscheduled arrival or early departures, I may not be eligible for further treatment in the future _____ **(pt. initial)**

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3) **I must provide accurate, up-to-date information concerning my dental and medical health history.** Failing to do so can compromise my oral and systemic health_____ **(pt. initial).**
4) **Treat students, faculty, and staff with respect.** I understand any disrespectful behavior toward students, including but not limited to verbal abuse, harassment, or discriminatory remarks, will not be tolerated and is grounds for dismissal from the clinic_____ **(pt. initial).**
5) **Take or provide a current set of dental x-rays.** Current x-rays are critical for comprehensive care. I will either take the x-rays that are due or I will provide current x-rays from my dentist in a timely manner. I understand I cannot receive any dental care without current x-rays as it is a liability to myself as a patient and the student as a clinician_____ **(pt. initial).**

PATIENT RIGHTS

You have a right to be treated with respect and consideration. Rose State College does not discriminate against any person due to race, class, age, gender, physical limitations, sexual preference or infectious disease status. Medical and dental records are treated as confidential. Faculty, students and staff will respect the privacy of patients and hold in confidence all information obtained in the course of their duties as required by law and institutional policy. If a patient presents with a condition which exceeds the skill level of the dental hygiene or dental assisting student, the patient will be referred to a private dentist or dental agency for treatment.

Patient treatment in the Rose State College Allied Dental Programs Clinic will include a complete diagnostic work-up, dental hygiene care (cleaning), personal oral hygiene education, periodontal scaling and fluoride therapy. The diagnostic work-up consists of a review of personal, medical and dental history, an extra-oral and intra-oral examination, hard tissue charting, soft tissue charting (observation and assessment of the gingiva and supporting bone structures), and a dental hygiene treatment plan. All diagnostic radiographs may be sent to your private dentist at your request.

As a patient in the Clinic, you have a right to receive the following information about your treatment: nature of and need for procedure, benefits of the procedure, any risks involved, outcomes if the procedure is not performed or completed, and the cost of the procedures.

I have read and completely understand the above information. My signature also verifies that I have received the written Notice of Privacy Practices as applied to this treatment facility.

Printed Name _____ Signature_____

Date: _____

Are you a current employee or student at Rose State College? YES NO (please circle)

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ROSE STATE COLLEGE

Office of Marketing and Public Relations

I, _____ (please print),

_____ DO

_____ DO NOT

give Rose State College and/or its representatives permission to use my photograph(s), videotaped images, name and/or personal quotes for the promotion of the College's activities in printed advertisements and brochures, billboard advertisements, the college web site and other promotional materials.

_____

Address

_____ _____

Zip Phone

_____

Email address

_____

Signature (If a minor, then parent or guardian)

_____

Date