RSC ALLIED DENTAL

Rose State College Dental Clinic

Personal and Health History- Minor

2026-2027

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:			
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. Is your child available for multiple and lengthy appointments? Y N (circle one)
2. Is your child in good health? Y N
3. Does your child have a primary care physician (pediatrician or family doctor)? Y N
4. Is your child currently under the care of a specialist for any medical condition? Y N
   If yes, please be sure the physician's information is listed above.
5. Has there been any change in your child's general health in the past year? Y N
6. When was your child's last physical examination?

_____

7. Has your child ever had a serious illness or operation? If so, what was it?

_____

8. Has your child been hospitalized within the past five years? If so, for what?

_____

9. Is your child fearful of dental treatment? On a scale of 1 (completely comfortable) to 10 (very fearful) _____

10. Does your child have any food, drug, or other allergies? If so, what are they? _____

_____

11. What medications is your child 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.

1. Damaged or artificial heart valve		29. Sinus problems		46. Hepatitis or liver problems	
2. Congenital heart lesion		30. Asthma		47. Eating disorder	
3. Infective endocarditis		31. Cough up blood or tuberculosis		48. Rheumatoid arthritis or other autoimmune condition	
4. Other heart condition		32. Persistent cough		49. Osteoarthritis (joint pain)	
5. Artificial joints		33. Stomach ulcers		50. Diabetes	
6. Shunts		34. Kidney problems		51. Frequent urination	
7. Fainting, seizures, or epilepsy		35. Low blood pressure		52. Excessive thirst	
8. Thyroid disease		36. High blood pressure		53. Dry mouth	
9. Mental health disorder		37. Service dog		54. Relative w/diabetes	
10. Frequent headaches		38. Hearing impairment		55. Anemia	
11. Cold sores, oral herpes		39. Vision impairment		56. Sickle cell anemia	
12. Cancer		40. Mobility aids (walker, wheelchair, etc.)		57. Had a blood transfusion	
13. AIDS or other immune system condition		41. Cerebral palsy		58. Blood disorder	
14. HIV positive status		42. Developmental disorder		59. Bruise easily	
15. Periodontal (gum) disease		43. Autism spectrum or neurodivergence		60. Tonsils and/or adenoids removed	
16. Drug or alcohol dependency		44. Surgery or radiation of the head or neck		61. Abnormal bleeding after dental or other medical care	
17. Has taken steroids in the past year		45. Uses nicotine in any form (vape, smoke, etc.)		62. Serious problems after dental treatment	

63. Does your child have any other condition not listed above?

_____

64. Is there anything we need to know about providing your childcare?

_____

65. Does your child experience mouth breathing or snoring?	Y	N
66. Has your child had sealants? (circle one)	Y	N
67. If sealants are needed, are you interested?	Y	N
68. Do you consent to the application of topical fluoride to reduce cavity risk?	Y	N

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

Parent/Guardian Signature: _____ Date: _____

TO OUR MINOR PATIENT'S FAMILY AND FRIENDS

We welcome you and your child to our Allied Dental Programs Clinic. We appreciate your cooperation and assistance in the education of our Rose State College Allied Dental Program students. It is important that you are aware of the policies, procedures and goals of our clinic. 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 consultation with a dentist regularly for examination, diagnosis, and treatment.

Our Allied Dental Program students will be providing clinical services for your child in a teaching situation. Our policy of not allowing family members or friends into the treatment area enables us to provide optimum dental hygiene care and establish rapport with the minor patient. This rapport will enable your child to trust and feel comfortable with other dental professionals during future dental visits.

Clinic policy requires that you remain in the building while the minor patient, 1-12 years old, is in our Clinic. This is important for the delivery of dental care to your child and the education of the RSC Allied Dental Program students. It is not required that minors 13 years or over have an adult present while the minor is in the Clinic.

Providing patient care must be mutually beneficial for you, the child and our students. If this is not the case, referral to another facility will be necessary. A fee of $5.00 (five dollars) is charged at each initial dental hygiene care (cleaning) appointment. Upon completion of your child's appointment, you will be advised of his/her dental condition. Your awareness and acceptance of these policies will make this visit more pleasant.

If it is determined that your child needs radiographs, a student may contact you separately from his/her dental hygiene care appointment. By signing this letter, you give consent for the following procedures: dental hygiene care (cleaning), fluoride treatment, sealants, radiographs (x-rays), intra-oral photographs and individual photographs as needed.

Thank you,

The Allied Dental Programs Faculty

I have read and completely understand the above information.

_____

Printed Patient Name

_____ Date_____

Signature (Parent/Guardian)

My signature verifies that I have received the written Notice of Privacy Practices as applied to this treatment facility.

Signature_____ Date_____

RSC ALLIED DENTAL

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 or scans. These impressions and scans 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: _____

RSC ALLIED DENTAL

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 website and other promotional materials.

_____
Address

_____ _____
Zip Phone

_____
Email address

_____
Signature (If a minor, then parent or guardian)

_____
Date