

Rose State College Dental Clinic
Personal and Health History- Adult
2026-2027

Please print in black or blue ink and complete all spaces. **No blanks**—if not applicable, write
 “N/A” or place a dash (—).

Name:		
<i>(last)</i>	<i>(middle initial)</i>	<i>(first)</i>
Preferred Name:		Preferred Pronouns:
Gender:	Date of Birth:	Age:
Place of Birth:	Occupation:	
Home Address:		
<i>(street)</i>	<i>(city)</i>	<i>(state, zip code)</i>
Phone:	Cell Phone:	
Email Address:		
Emergency Contact:	Relationship:	Phone:
Last Dental Visit Date:	Purpose:	Last Dental X-ray Date:

1. Are you available for multiple and lengthy appointments? Y N (circle one)

2. Are you in good health? Y N

3. Has there been any change in your general health in the past year? Y N

4. Do you have a primary care physician? Y N

5. If “Yes” to #4, when was your last physical examination? Please list any significant findings: _____

6. Are you currently under the care of a specialist for any medical condition? Y N

7. If you answered “Yes” to #6, please provide your specialist’s full name, office address, and phone number: _____

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

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

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

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

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

Please place an "X" next to each condition you have or have previously been diagnosed with.

13. Damaged or artificial heart valve	
14. Congenital heart lesion	
15. Heart disease (heart attack, hardening of the arteries, etc.)	
16. Infective endocarditis	
17. Chest pain	
18. Pacemaker	
19. Stroke	
20. Artificial joints	
21. Shunts	
22. Fainting, seizures, or epilepsy	
23. Thyroid disease	
24. Mental health disorder	
25. Frequent headaches	
26. Cold sores, oral herpes	
27. Periodontal (gum) disease	
28. Sexually transmitted infection	
29. HIV positive status	
30. AIDS or other immune system condition	
31. Cancer	
32. Eating disorder	
33. Drug or alcohol dependency	

32. Sinus problems	
33. Asthma	
34. Cough up blood or tuberculosis	
35. Persistent cough	
36. Stomach ulcers	
37. Kidney problems	
38. Hepatitis or liver problems	
39. Low blood pressure	
40. High blood pressure	
41. Service dog	
42. Hearing impairment	
43. Vision impairment	
44. Mobility aids (walker, wheelchair, etc.)	
45. Cerebral palsy	
46. Developmental disorder	
47. Autism spectrum or neurodivergence	
48. Surgery or radiation of the head or neck	
49. Have taken bisphosphonates (Fosamax, Boniva, etc.)	
50. I have taken steroids in the past year	
51. Regularly exposed to x-rays due to employment	

52. Emphysema	
53. COPD	
54. Rheumatoid arthritis or other autoimmune condition	
55. Osteoarthritis (joint pain)	
56. Diabetes	
57. Frequent urination	
58. Excessive thirst	
59. Dry mouth	
60. Relative w/diabetes	
61. Anemia	
62. Sickle cell anemia	
63. Had a blood transfusion	
64. Blood disorder	
65. Bruise easily	
66. Abnormal bleeding after dental or other medical care	
67. Serious problems after dental treatment	
68. Removable denture, partial, or appliance	
69. Dental implants	
70. Currently pregnant	
71. Anticipate becoming pregnant	

72. Do you have any other conditions 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: _____

**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 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 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 departure, I may not be eligible for further treatment in the future. _____ (pt. initial)

- 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)
- 6) **Clinic Policy Regarding Unattended Children.** For the safety of our patients, students, and staff, children are not permitted in the clinic with adult patients during appointments. Children may not be left unattended in the lobby. If a patient arrives with unattended children, the appointment will be cancelled and rescheduled for a later date.
_____ (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 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 will be sent to your personal e-mail.

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)



**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: _____

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

