East Tennessee State University
College of Clinical and Rehabilitative Health Sciences
Dental Hygiene Program
Johnson City, TN 37614-1709

Medical History

Medical Alerts

Date ____________________

Name ______________________________________ (LAST / FIRST / MIDDLE) Home Phone (____) ____________

Address ______________________________________ (NUMBER, STREET) Business Phone (____) ____________

City ____________________ State ____________ Zip Code ____________

Occupation ______________________________________

Date of Birth ___/___/___ (MO DAY YR) Sex: M F Height ______ Weight _____

Person to contact in case of emergency ______________________________ Phone (____) ____________

If the person listed above is a minor, is permission granted for: X-rays: ❑ Yes ❑ No **and/or Sealants:** ❑ Yes ❑ No

Parent/Guardian Signature ______________________________

The following questionnaire must be completed before any treatment is rendered. The information is for our records and is considered confidential.

Describe your current dental problem: ______________________________

1. Have you or your family recently experienced any of the following medical conditions?:
   a. TB .... Yes No
   b. Fever .... Yes No
   c. Night sweats .... Yes No
   d. Persistent cough that produces blood .... Yes No
   e. Unexplained weight loss .... Yes No

ORAL HEALTH

2. The name and city of my dentist is: ______________________________
3. The name and city of my physician(s) is: ______________________________
4. Are you currently having any dental problems? .... Yes No
5. Have you ever been treated for Periodontal Disease (gum disease, pyorrhea, trench mouth)? .... Yes No
6. Do your gums ever bleed when you brush, floss, or for no apparent reason? .... Yes No
7. Have you ever been shown proper brushing and flossing techniques? .... Yes No
8. Do you use any oral cleansing mechanisms in addition to a toothbrush and floss? .... Yes No
9. How often do you brush? ____________
10. How often do you floss? ____________
11. Do you have sores, swellings, or blisters on your gums, cheeks or lips? .... Yes No
12. Have you had orthodontic treatment? .... Yes No
13. Have you had any serious trouble associated with any previous dental treatment? .... Yes No
    If so, explain: ______________________________
14. Are you wearing removable dental appliances? .... Yes No
15. Dental treatment history:
    a. Last dental visit ____________
    b. Last dental x-rays ____________
    c. Last cleaning ____________
16. Are you in good health? .... Yes No
17. Has there been any change in your general health within the past year? .... Yes No
18. My last physical examination was on ____________
19. Are you now under the care of a physician? .... Yes No
    If so, what is the condition being treated? ______________________________
20. Have you had any serious illness, operation, or hospitalization? .... Yes No
    If so, what was the illness or problem? ______________________________
21. Have you used tobacco products within the past year? Yes No
22. Do you have or have you had any of the following diseases or conditions?
    a. Allergy .... Yes No
    b. Arthritis or painful swollen joints .... Yes No
    c. Asthma .... Yes No
    d. Cancer .... Yes No
    e. Cardiovascular disease (heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, congestive heart failure) .... Yes No
       1. Do you have chest pain upon exertion? .... Yes No
       2. Are you ever short of breath after mild exercise or when lying down? .... Yes No
       3. Do your ankles swell? .... Yes No
       4. Do you have congential heart defects? If so explain ____________ Yes No
       5. Do you have a cardiac pacemaker? .... Yes No
       6. Do you have artificial heart valves or have you had a heart transplant? .... Yes No
       7. Do you have a history of infective endocarditis? Yes No
    f. Stroke? .... Yes No
    g. Diabetes: what type? ____________ .... Yes No
       1. Slow-healing cuts .... Yes No
       2. Frequent thirst .... Yes No
       3. Frequent urination (more than 6 times/day) .... Yes No
       4. Increase in appetite with no weight gain .... Yes No
    h. Epilepsy, seizures, or other neurological disease .... Yes No
    i. Fainting spells .... Yes No

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Continue on Back

j. Hepatitis, jaundice or liver disease........................ Yes No
k. HIV or AIDS infection.. Yes No
l. Joint replacement.. Yes No
m. Kidney trouble .... Yes No
n. Low blood pressure.. Yes No
o. Persistent diarrhea or recent weight loss .... Yes No
p. Persistent swollen glands in neck .... Yes No
q. Problems of the immune system........................... Yes No
r. Problems with mental health .... Yes No
s. Respiratory problems, emphysema, bronchitis, etc. .... Yes No
t. Sexually transmitted disease................................. Yes No
u. Sinus trouble or hay fever...................................... Yes No
v. Stomach ulcer, hyperacidity or gastric reflux .... Yes No
w. Thyroid problems.. Yes No
x. Chronic pain .... Yes No
y. Eating disorder .... Yes No

23. Have you had abnormal bleeding?............................ Yes No
    a. Have you ever required a blood transfusion?......... Yes No
24. Do you have any blood disorder such as anemia?...... Yes No
25. Have you ever had any treatment for a tumor or growth?... Yes No
26. Are you allergic or have you had a reaction to:
    a. Aspirin?... Yes No
    b. Barbiturates, sedatives, or sleeping pills?............. Yes No
    c. Codeine or other narcotics?................................. Yes No
    d. Iodine?.. Yes No
    e. Local anesthetics?.. Yes No
    f. Penicillin or other antibiotics? .... Yes No
    g. Sulfa drugs? .... Yes No
    h. Latex?.. Yes No
    i. Other?.. Yes No
27. Do you have any disease, condition, or problem not listed above that you think I should know about? ...... Yes No
    If so, explain ______________________________

Women:

28. Are you pregnant? .... Yes No
29. Do you have any problems associated with your menstrual period?.. Yes No
30. Are you nursing?... Yes No
31. Are you taking birth control pills? .... Yes No

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 ETSU, or any other member of this staff, responsible for any errors or omissions that I may have made in the completion of this form.

Blood Pressure ______________________

Respiration ______________________

Pulse ______________________

Temperature ______________________

Blood Glucose/HbA1c ______________________

____
SIGNATURE OF PATIENT

____
SIGNATURE OF STUDENT

____
SIGNATURE OF INSTRUCTOR

Please list all medications / herbal remedies that you are taking:

DRUG	CLASSIFICATION	DENTAL CONSIDERATION

Tobacco Use Survey

Name____Date_____________

1. Do you **use** tobacco in any form? yes_____ no_____

1A. If no, have you **ever used** tobacco in the past? yes_____ no_____
How long did you use tobacco? Years_____ months_____
How long ago did you stop? Years_____ months_____

If you are **not currently** a tobacco user, no other questions should be answered. Thank you for completing this form.

*Questions 2 to 10 are for **current** tobacco users only.*

2. **If you smoke**, what type? (check) How many? (number)
Cigarettes_____ cigarettes per day_____
Cigars _____ cigars per day _____
Pipe _____ bowls per day _____

3. **If you chew/use snuff**, what type? How much?
Snuff _____ days a can last _____
Chewing _____ pouches per week _____
Other(Describe)____________amount_______per_____

3A. **How long** do you keep a chew in your mouth? Minutes____

4. **How many days** of the week do you use tobacco? 7 6 5 4 3 2 1

5. **How soon** after you wake up do you first use tobacco? Within 30 minutes_____
more that 30 minutes____

6. Does the person **closest to you** use tobacco? yes____ no____

7. **How interested are you** in stopping your use of tobacco? not at all____,
a little___, somewhat___, yes___, very much___.

8. Have you **tried to stop** using tobacco before? yes____ no____

8A. How long was your **last try** to stop? years___ months____ weeks____ days____

9. Have you **discussed stopping** with your physician? yes____no____

10. If you decided to stop using tobacco completely during the next two weeks, **how confident are you** that you would succeed? Not at all____, a little____, somewhat____, very confident____.

Thank you for completing this form.
from *How To Help Your Patients Stop Using Tobacco*, NIH, 1998. Appendix E.

EAST TENNESSEE STATE UNIVERSITY
DENTAL HYGIENE CLINIC
PATIENT CONSENT FORM

Welcome to the ETSU Dental Hygiene Clinical Program. This program is designed to provide a thorough education experience for students while providing quality preventive services. In order to accomplish these objectives, please read carefully the following policies of this department.

1. The services provided in this clinic are not a substitute for the routine checkup and regular services provided by a dentist.
2. All new patients as well as patients who have not visited this clinic within the past two years will be required to first obtain a one-hour screening appointment. Upon completion of this appointment, you will then be assigned to a student.

Simple cases may not be seen in our clinic depending on appointment availability.
These patients should seek dental treatment from their private dentist if not contacted by this clinic within six months.

EVEN THOUGH YOU HAVE BEEN THROUGH THE SCREENING PROCESS, YOU ARE NOT GUARANTEED A CLEANING APPOINTMENT.

3. Student hygienists are performing these services; appointments will be lengthy and may require multiple visits.
4. X-rays will be sent to your private dentist on request, for a small fee.
5. Students follow a strict schedule, please be on time for appointments.
6. Cancellation policy: Cancellations are requested 24 hours in advance of the appointment to allow the student hygienist an opportunity to fill the appointment time. The students' clinical course responsibilities are extensive and dependent on patient compliance with appointments as scheduled. Therefore when a patient has two (2) cancellations documented in his/her file, we have the right to discontinue dental hygiene services from East Tennessee State University Dental Hygiene Clinic. We appreciate your time and consideration of these policies. Please sign below and return this form to the receptionist.
7. You may be denied treatment, if your condition is beyond the scope of our clinic.
8. Sometimes during the course of dental hygiene treatment, unexpected consequences may occur (such as losing a filling or crown). The dental hygiene clinic is not responsible. We do not have the personnel/equipment necessary for routine restorative care; therefore, we recommend that you see your family dentist for the necessary repair/treatment.
9. Permission is hereby given for treatment documented in my treatment plan and agreed upon by myself, my student clinician and faculty member including but not limited to x-rays, photographs, sealants, fluoride treatment, etc.

Thank You,
ETSU Dental Hygiene Program

____________________________ ____________________________

Signature Date

PATIENT'S BILL OF RIGHTS

Patients receiving dental hygiene therapy at the Dental Hygiene Clinic at East Tennessee State University have the right to...

1. Informed participation in all decisions involving patient's dental hygiene therapy program.
2. Privacy regarding source of payment for therapy. This includes access to care without regard to source of payment.
3. Complete and accurate information concerning the scope of care provided in the dental hygiene clinic.
4. Explanation in layman's terms of all proposed procedures including possibility of risks and side effects.
5. A complete and accurate evaluation of patient's condition and prognosis without treatment before giving treatment consent.
6. Designate another person to make treatment decisions for the patient.
7. Identify professional status and experience of all those providing care.
8. Not be discriminated against based on race, religion, national origin, sex, handicap or sexual orientation.
9. All information in patient's record.
10. Not have any test or procedure designed for educational purposes rather than the patient's direct personal benefit without the patient's consent.
11. Refuse any particular drug, test or treatment.
12. Privacy of both person and information.
13. Informed consent including the following:
    a. Description of recommended treatment
    b. Description of risks and benefits of recommended treatment
    c. Description of alternatives including risks and benefits of alternatives
    d. Probability of success and what the therapist means by success
    e. Problems anticipated in recuperation
    f. Any other information generally provided by qualified therapist.
14. Comprehensive dental hygiene therapy.
15. Referral to dentist of record for examination and evaluation.
16. Request forwarding of dental records and radiographs to their dentist of record.
17. Expect treatment be delivered as scheduled.
18. Information regarding patient distribution and eligibility for treatment.

FEE SCHEDULE

SERVICE	AMOUNT
Dental Cleaning	$ 20
Senior Citizens (Age 55 and Over)	No Charge for Cleaning
Sealants	$12 each
Full Mouth Radiographs/Panoramic	$30
Bite Wing Radiographs	$20
Single Film	$ 5
No payment is required for x-rays unless the films are removed from the clinic by request of the patient or the patient's dentist of record.	