PATIENT REGISTRATION:

Please complete at each appointment so that we can update your information.

First Name: ______ Last Name: ______

Please circle: Male or Female

Address: ______ Date of birth: ______

City, State, Zip: ______

Home Phone: _____ Cell Phone: _____ Work Phone: ______

MEDICAL HISTORY

Have you ever had a serious head or neck injury? Yes No If yes, please explain: Are you taking any medications, pills, or droug? Yes No Osy Use to taken, Phen-Fen or Redux? Yes No Osh Have you taken, Phen-Fen or Redux? Yes No Osh Have you ever taken Fosamax, Borinxa Actoriel of any Yes No Osh Have you ever taken Fosamax, Borinxa Actoriel of any Yes No Dyou use controlled substances? Yes No No Dyou use controlled substances? Yes No No Dyou use controlled substances? Yes No No Nursing? Yes No Are you allergic to any of the following? Asplin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs Other If yes, please explain: Do you have, or have you had, any of the following? AlbSrikt Postative Ves No Consone Medicine Yes No Hepatitis A Ves No Recent Weight Loss Yes No Anaphylasis Yes No Diabetes. Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Anaphylasis Yes No Easily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Anaphylasis Yes No Easily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Anaphylasis Yes No Epilepsy or Selzures Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Anaphylasis Yes No Epilepsy or Selzures Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Anaphylasis Yes No Epilepsy or Selzures Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Anaphylasis Yes No Epilepsy or Selzures Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Hepatitis B or C Yes No No Hep	PATIEN	NT NAME			Birth Da	te		
Are you under a physician's care now? Yes No If yes, please explain: Are you taking any medications, pilis, or drugs? Yes No If yes, please explain: Are you taking any medications, pilis, or drugs? Yes No If yes, please explain: Do you take or howe you taken, Phen-Fan or Redury? Yes No If yes, please explain: Do you take or howe you taken, Phen-Fan or Redury? Yes No Other medications containing bishosphonating bishosphonat	have, or medication	n that you may be	reat the area in and a taking, could have ar	round your mouth important interre	, your mouth is a part lationship with the de	t of your entire b	ody. Health problems theceive. Thank you for an	at you may nswering the
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University of Arkansas for Medical Sciences Dental Hygiene Clinic

The dental hygiene clinic (Clinic) of UAMS is a teaching facility designed to provide clinical education and experience to dental hygiene students while providing high quality preventive dental hygiene care to patients. Because teaching students is the primary responsibility of the Clinic, we would appreciate your patience and cooperation in assisting us in our efforts.

Clinic Policies

Appointments

- Appointments are scheduled for approximately 2 to 2 1/2 hours in length.
- We request your cooperation in appearing on time for your scheduled appointments.
- Depending on individual needs, several appointments may be necessary to complete treatment.
- We request your cooperation in appearing on time for your scheduled appointments. If you are more than 15 minutes late, your appointment may have to be rescheduled for another day.
- Please provide at least 24 hours notification if unable to keep dental appointment.
- If you do not appear for your appointment and haven't given us a notice then it will be considered a *broken appointment*. Broken appointments could result in your dismissal as a patient in our clinic. Habitual cancellations which are 3 or more could potentially result in dismissal from our clinic.
- Patients are to park in the UAMS Patient and Visitor parking decks. The Clinic does not pay for parking expenses.

New Patients

In the interest of providing comprehensive care to our patients, the UAMS Dental Hygiene Clinic will provide all new patients over the age of 18 years an appointment for a "New Patient Evaluation" which will include the following:

- Medical history review
- Intra/Extraoral examination
- Dental charting and examination by the supervising dentist
- An evaluation of your periodontal condition (gum disease) will be completed.
- Appropriate radiographs (x-rays) as determined by individual needs
- Examination by the dental hygiene instructor
- Individualized patient education
- Oral hygiene instructions
- Treatment planning
 - The approximate cost of your treatment and approximate number of appointments needed will be explained at this time.
 - o If you require advanced periodontal (gum disease) treatment, several appointments may be required to complete your care.
 - Treatment alternatives, expected outcomes of treatment, and risks of no treatment will be discussed with you.
- The cost for this service is \$30.00 which includes x-rays.

• NO cleaning will be performed at this time. As outlined in the treatment plan developed, you will be reappointed for the appropriate type and number of appointments.

X-rays

- X-rays are a necessary part of your diagnosis and treatment; therefore, current x-rays are <u>required</u> of all patients.
- The type of x-rays prescribed by the dentist will be based upon your individual needs.
- Updated x-rays can be taken here or mailed to us from your dental office.
- If taken here, the x-rays can be mailed to your dentist upon your request after they have been evaluated/graded by the supervising dentist (usually 1-3 day time frame).
- Refusal to have x-rays taken or provide current x-rays from you dentist's office will prevent us from being able to see you in our clinic as x-rays are necessary for the best patient care.

Infection Control

- For your protection, all dental instruments are sterilized and dental units are disinfected after each patient.
- Students and faculty are required to wear masks, gloves, and glasses during patient treatment.
- The Department of Dental Hygiene maintains the infection control guidelines of the Centers for Disease Control and Prevention (CDCP) and the Occupational Safety and Health Administration (OSHA).

Payment

- Payment of services is due at the time treatment is provided.
- Because we do not bill for services, payment must be made by credit/debit cards or check only.
- You will be given a receipt for services and fees. Fees for services are posted in the reception area.

Children and Minors Under 18

- All minors must have the medical history and consent for treatment signed by a parent or guardian prior to treatment.
- No children are allowed in the clinic area unless being treated as a patient.
- Our clinic is not equipped to provide child care or babysitting services. Please make proper arrangement to have your children properly supervised when you are receiving treatment.

Cellular Phones

The operation or use of cellular phones in the clinic is prohibited. We ask all patients to turn **OFF** or place your device on **MUTE** while in the clinic area. Students are not allowed the use of such devices in order to focus on your treatment. Therefore, we ask that you return the same respect to our students and faculty by refraining from making or receiving phone calls or text messages in the clinic.

UAMS Dental Hygiene Clinic Patient Rights

- As a patient, you have the right to considerate and high quality dental hygiene care appropriate to your needs.
- All treatment will be rendered under the supervision of UAMS faulty members and meet the highest standards recognized by the dental hygiene profession for practice.
- The UAMS Dental Hygiene Clinic does not discriminate on the basis of age, sex, race, or handicapping condition. Should you require special care due to a hardship, please inform our staff.
- After a comprehensive oral examination you will be informed of your oral health status and treatment needs.
- You have the right to refuse any or all treatment at which time you may be referred for treatment elsewhere.
- Upon your acceptance of the recommended treatment, it is your responsibility to make your scheduled appointments and complete the treatment planned for you.
- The treatment performed may not constitute full and comprehensive dental care. Should you require additional dental care, you will be provided a referral letter of the treatment needed in order that you may seek dental care from the dentist of your selection.
- My signature below indicates that I have received a copy of the UAMS Dental Hygiene Clinic Policies and Patient Rights Statement, and that I have read these policies and agree to follow by the stated policies of the UAMS Dental Hygiene Clinic with regard to:
 - o Appointment length, broken appointments, parking
 - New patient evaluation appointments
 - X-rays
 - Infection control standards
 - Payment
 - Treatment of minor patients

	Consent for Treatment
•	I have received, read, and signed the UAMS Notice of Privacy Practices form. I understand that the care provided is primarily preventive in nature and does not constitute comprehensive dental care. I understand that all diagnostic aids, including radiographs and/or photographs are the property of the Clinic. I further authorize the administration of such anesthetics and medications as are considered necessary for my treatment. I hereby give my consent for my initial care and all subsequent care to the faculty and students of the Department of Dental Hygiene to provide any and all necessary diagnostic and dental hygiene services for myself or, my child, (child's name) unless affirmatively revoked in writing. If child, relationship to patient:
Signature:	Date:

Signature: Date:

(Place MR Label Here) MR#: Patient's Name: Patient's Address:



Acknowledgment of Receipt of Privacy Notice

By signing this form, you are only agreeing that you have <u>received</u> a copy of the UAMS Notice of Privacy Practices.

Patient Signature	Date/Time	
Print Legal Representative's Name (if applicable)	Legal Representative's Signature	
If Legal Representative, authority of Legal Representations (such as parent of a minor, guardian, administrator of appointed with power of attorney, or healthcare proximal pr	estate of deceased, attorney-in-fact	
STAFF	USE ONLY	
We provided the Notice of Privacy Practices and atterbut acknowledgment could not be obtained because:	npted to obtain written acknowledgment	
Patient or Legal Representative declined to sig	n the Acknowledgment of Receipt.	
Patient or Legal Representative declined to sig		



Med Rec 2339 (03/07) HIPAA