COVID-19 Patient Self Screening Form

Regardless of your vaccination status:

1. Have you experienced any of the following symptoms within the last 48 hours?
   (Note: please answer "yes" if you are experiencing any of the following symptoms, despite if you believe they are associated with the COVID-virus)
   - ☐Yes ☐ No **Fever or chills**
   - ☐Yes ☐ No **Cough**
   - ☐Yes ☐ No **Shortness of breath and/or difficulty breathing**
   - ☐Yes ☐ No **Fatigue (unusual or unexplainable tiredness)**
   - ☐Yes ☐ No **Muscle or body aches**
   - ☐Yes ☐ No **Headache**
   - ☐Yes ☐ No **New loss and/ or taste of smell**
   - ☐Yes ☐ No **Sore throat**
   - ☐Yes ☐ No **Congestion and/or runny nose**
   - ☐Yes ☐ No **Nausea or vomiting**
   - ☐Yes ☐ No **Diarrhea**
2. ☐Yes ☐ No Have you traveled outside United States in the last 14 days? Or traveled overnight *AND* used public transportation OR any overnight trip with persons outside of your household?
3. ☐Yes ☐ No Have you been in contact with anyone who has tested positive for COVID- 19?
4. ☐Yes ☐ No Have you tested positive with COVID-19 (or concerned that you may have COVID-19)?

I,____________________________, understand that my participation in the dental screening is voluntary. I am freely and voluntarily choosing to participate in the dental screening, being fully aware of the potential risk related to the transmission of the COVID-19 virus. I have had all of my questions addressed and am waiving any claim I might have, now or in the future, related to any injury or illness I could potentially sustain due to participation in the dental screening. I also waive any liabilities to any person or entity associated with the Dental Hygiene Program at West Georgia Technical College as it relates to the exposure risk of COVID-19. Furthermore, I am giving my express permission to be medically examined prior to commencing the dental screening.

This _________day of _______________________ , 2024.

Patient's Name (Print) ____

Patient's Signature: ____ **Student**

Signature: ____

This form must be entirely completed and documented in the patient's records prior to patient escort and any rendered service within the clinic

(**Payment Due First Day of Service**)

Patient Name:____ Medical Alert: ____________________

Date of Birth: ___________________ Sex: M or F Email: _________________________________

Home Street Address: ____

City:___________________ State:__________ Zip: ___________

Home Phone ( )____________Cell Phone ( )____________ Work Phone ( ) _____________

Physician's name, address, and telephone number: ____

____

Emergency Contact and Number ____

Are you Pregnant? YES or NO. If Yes, what Trimester? ____

Welcome! **<u>To the West Georgia Technical College- Douglasville Dental Hygiene Clinic</u>**

Our goal is to assist you in eliminating and preventing oral disease so that you may keep your natural teeth healthy. It is our desire to provide considerate, respectful, and confidential dental hygiene care.

Since our goal is comprehensive dental hygiene care and the student is responsible for providing complete services, your participation in his/her learning experience is essential. <u>It is important for you to understand that this is an educational setting that the **student's grade depends on your full cooperation**</u>**.** If for some reason you will not be able to keep an appointment, **please call the clinic 48 hours in advance** so that the student can make plans to see another patient during that time.

Your **first visit** will involve a thorough examination, which will include the following procedures:

1. A medical history to determine general health and any specific conditions altering the process of your treatment.
2. A comprehensive oral examination to detect the possible presence of abnormal tissues.
3. A preliminary report of your oral health status, recommended treatment, treatment alternatives, option to refuse treatment, risk of no treatment, and expected outcomes.
4. A dental hygiene treatment plan to inform you of treatment process and number of appointments necessary.
5. X-rays if indicated.
6. Oral health instructions, which will continue at all subsequent visits.
7. Referral to a dentist or physician for evaluation of noted conditions.
8. Because this is a learning institution, radiographs and chart information may be used for educational purposes.

Most patients require **more than one visit** for the completion of services. We strive to keep the number of appointments required to a minimum, as we realize that your time is valuable. **Please be prompt** so that we can serve you and others without necessary delay. Occasionally unforeseen situations arise and will cause us to run behind schedule. However, every effort will be made to keep you from waiting any longer that is absolutely necessary.

We thank you for making your appointment with us and look forward to serving you!

Date__________________Patient Signature____

Rev 5/2014

WGTC Dental Hygiene
Program Requirements

Medical and Dental History

Patient Name: **Date of Birth / /**

When did you last see your Physician? When was your last physical examination? Are you required to Pre-Medicate before dental appointments? Yes or No - If Yes, why?
Has there been any changes in your general health within the last year? Yes or No… I f yes, what changed?
Are you currently under the care of your physician? Reason? Results? What condition(s) is being treated?
Have you had any serious accidents, illness, or operation? If so, what & when?
Have you been out of the continental United States in the last 30 days? If yes, where?

Do you have or have you had any of the following? Y (yes) N (no)

	Y	N			Y	N	
Cardiovascular	☐	☐	Angina pectoris	**Respiratory**	☐	☐	Tuberculosis
	☐	☐	Myocardial Infarction		☐	☐	Emphysema
	☐	☐	Congenital heart defect		☐	☐	Asthma
	☐	☐	Rheumatic fever		☐	☐	Persistent cough or cough up blood
	☐	☐	Rheumatic heart disease		☐	☐	sinus trouble
	☐	☐	Heart murmur		☐	☐	Hay fever
	☐	☐	Hypertension		☐	☐	Sleep Apnea
	☐	☐	Stroke				
	☐	☐	Recurrent sore throats				
	☐	☐	Chest pain upon exertion				
	☐	☐	Shortness of breath				
	☐	☐	Short ness of breath while laying down				
	☐	☐	Require extra pillows to sleep				
	☐	☐	Other heart condition: ________________				
Endocrine	☐	☐	Diabetes If, Yes: Current A1C _________	**Hematopoietic**	☐	☐	Anemia
	☐	☐	Adrenal disorders		☐	☐	bleeding disorder
	☐	☐	Thyroid disorders		☐	☐	Leukemia
	☐	☐	Parathyroid disorders		☐	☐	Abnormal bleeding associated with previous extractions, surgery, or injury
	☐	☐	Urination more than 6 times a day		☐	☐	Excessive bruising
	☐	☐	Excessive thirst		☐	☐	Blood transfusion
	☐	☐	Family history of diabetes				
Neurologic	☐	☐	Paralysis	**Musculoskeletal**	☐	☐	Prosthetic joint replacement
	☐	☐	Epilepsy		☐	☐	Arthritis
	☐	☐	Convulsions		☐	☐	Bone disorders
	☐	☐	Fainting spells or seizures		☐	☐	Muscular disorders
	☐	☐	anxiety		☐	☐	Inflammatory rheumatism
	☐	☐	psychiatric treatment				
GI/Liver	☐	☐	Ulcers	**Genio-urinary**	☐	☐	Kidney dialysis
	☐	☐	Hepatitis		☐	☐	Kidney infections
	☐	☐	Jaundice		☐	☐	Leukemia
	☐	☐	Cirrhosis		☐	☐	Sexually transmitted disease (STD)

To the best of my knowledge, the above medical and dental history is correct. I hereby consent to such examinations, radiographs (x-rays), diagnostic procedures, and tests that may be prescribed. I assume any risk associated with any treatment performed. Students, faculty, nor facilities may be used for personal gain nor profit. Records become property of West Georgia Technical College-Douglasville.**Rev3/2019cm**

Signature:____Date:___________________________

Guardian signature if patient under 18 years of age

WEST GEORGIA TECHNICAL COLLEGE
DENTAL HYGIENE PROGRAM
MEDICAL AND DENTAL HISTORY

PATIENT NAME: _ DATE OF BIRTH: / /_

OTHER

Y	N	
☐	☐	Pregnant or nursing
☐	☐	HIV or AIDS
☐	☐	Cancer
☐	☐	Skin rashes or hives
☐	☐	Chemotherapy
☐	☐	Radiation y Therapy

Please list any other conditions or diseases below.

ALLERGIES

Y	N	
☐	☐	Allergies to local anesthetics
☐	☐	Allergies to antibiotics such as penicillin or sulfa
☐	☐	Allergies to codeine, aspirin, or other pain meds
☐	☐	Allergies to latex __________________

Please list any other allergies you may have below.

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS? PLEASE LIST EACH MEDICATION.

MEDICATIONS

Y	N		
☐	☐	Antibiotics	______________________
☐	☐	Anticoagulants (Blood thinners)	______________________
☐	☐	Antihistamines	______________________
☐	☐	Aspirin	______________________
☐	☐	Birth control or other hormones	______________________
☐	☐	Digitalis, nitroglycerin, other heart drugs	______________________
☐	☐	Diuretics	______________________
☐	☐	High blood pressure medication	______________________
☐	☐	Immunosuppressant's	______________________
☐	☐	Insulin, Tolbutamide, Orinase, or similar drug	______________________
☐	☐	Steroids	______________________
☐	☐	Thyroid medication	
☐	☐	Tranquilizers	
☐	☐	Bisphosphonates	
☐	☐	Other drugs, vitamins, herbs, over-the-counter drugs	______________________

DENTAL HISTORY

ANSWER THE FOLLOWING QUESTIONS RELATED TO YOUR DENTAL HISTORY.

Y	N	
☐	☐	Do you use tobacco products? Cigarettes Pipe Cigars Snuff Chew Amt daily_____How long?______
☐	☐	Do you go on diets? Frequently Occasionally Seldom
☐	☐	Do you consume alcoholic beverages? When was your last drink? ______________________
☐	☐	Are you wearing contact lenses?
☐	☐	Have you had radiographs (x-rays) of all of your teeth? When? ______________________
☐	☐	Have you had injuries to your mouth, teeth, or head?
☐	☐	Have you had difficulties associated with any previous dental treatment?
☐	☐	Are any of your teeth uncomfortable? Heat Cold Touch Chewing
☐	☐	Do your gums bleed easily?
☐	☐	Does food catch between your teeth? Where? ______________________
☐	☐	Are you conscious of bad breath or dry mouth?
☐	☐	Have you been told that you have gum disease?
☐	☐	Have you ever had periodontal (gum) treatment? Dentist's name: ______________________
☐	☐	Do you use a toothbrush and floss? How often? ______________________
☐	☐	Do you use a battery-operated toothbrush?
☐	☐	Do you use a soft, medium or hard manual toothbrush? _____________
☐	☐	Do you ever get canker sores or fever blisters?
☐	☐	Do you experience any difficulty in opening your mouth?
☐	☐	Does your jaw ever hurt, pop, or click?
☐	☐	Are you aware that you clench or grind your teeth?

What is the reason for your visit? ______________________

When was your last dental visit? ______________________

What was the approximate date of your last professional teeth cleaning?

To the best of my knowledge, the above medical and dental history is correct. I hereby consent to such examinations, radiographs (x-rays), diagnostic procedures, and tests that may be prescribed. I assume any risk associated with any treatment performed. Students and facilities may not be used for personal gain or profit. Records become property of West Georgia Technical College – Douglasville. **Rev. 12-2014**

Signature:____ Date:______________________________

Guardian signature required if patient under 18 years of age

WEST GEORGIA TECHNICAL COLLEGE DEPARTMENT OF DENTAL HYGIENE

Consent/Authorization for Treatment

- ☐ I understand this program is a training program and that my treatment will be rendered by a student clinician under supervision of qualified, licensed faculty.
- ☐ I understand that because of treatment by students that treatment may involve several hours in the clinic and may also involve several appointments to complete my treatment plan.
- ☐ Permission is hereby given for treatment documented in my treatment plan. Treatment by my student clinician and faculty member may include but may not be limited to x-rays, impressions of my mouth for study models, photographs, preventive chemotherapeutic agents, sealants, prescriptions and/or nonprescription medications, etc.
- ☐ I understand that these records may be used for educational purposes.
- ☐ I understand that his program renders preventive dental hygiene services, but does not render any restorative (restorations, crowns, bridges, dentures), surgical, (extractions, biopsies), nor provisional (temporary restoration, pain relief, infection treatment, root canals, orthodontic) treatment.
- ☐ I understand that during my treatment defective fillings may be dislodged or crowns may become loose. I understand that this can be, but is a rare, complication of dental hygiene care and I assume full responsibility for repair, cementation, or restoration replacement by my family dental practitioner.
- ☐ I understand that I may be referred to licensed practitioners for further treatment and I assume full responsibility to seek and have further treatment rendered.
- ☐ I understand that because this is an educational facility, I will not be able to have a dental cleaning at the recommended re-care interval and should visit my dental office routinely.

In the case of a minor or mentally handicapped patient, the consent(s) below is/are being given on his behalf.

Signature____Date: ________________

ACKNOWLEDGEMENT OF PRIVACY RIGHTS (you may refuse to sign this acknowledgement)

By signing below, I acknowledge that I have read and received the Program's notice of Privacy Policies and Individual right.

Signature____ Date: ___________

CONSENT TO OBTAIN MEDICAL RECORDS or INFORMATION (May be required for treatment)

- ☐ I hereby authorize West Georgia Technical College, Department of Dental Hygiene to obtain permission, medical information and/or records from my physician, physical assistant, nurse practitioner or other medical facility during my treatment.
- ☐ I understand that any obtained above information will be kept confidential in accordance with the Notice of Privacy Policies I have read and signed.

Signature____ Date: _____________________

WEST GEORGIA TECHNICAL COLLEGE DEPARTMENT OF DENTAL HYGIENE

CONSENT TO RELEASE MEDICAL INFORMATION (sign only one of the two following consents)

☐ I hereby authorize West. Georgia Technical College, Department of Dental Hygiene to release my protected health information and those of my children, to my spouse, family member or significant other or to any person(s) listed below:

1. ____
2. ____
3. ____

Signature ____ Date: ________________

(Do not sign below if you have agreed to above consent)

☐ I do not authorize any information to be released to anyone other myself.

CONSENT TO LEAVE MESSAGES

I hereby authorize messages to be left on a voicemail or answering system. Please provide the number(s) that staff and students may utilize to leave a message for ______________________
____

CONSENT TO RELEASE RADIOGRAPHS

I authorize release of radiographs to the following dentist. ______________________________

Signature ____

Dental office name and address: ____
____

I understand that I will be provided copies of current radiographs if there are no current charges on my account.

Signature ____ Date: ________________

WEST GEORGIA TECHNICAL COLLEGE DEPARTMENT OF DENTAL HYGIENE
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL AND DENTAL INFORMATION ABOUT YOU MAY BE USED, AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THESE POLICIES CAREFULLY.

1. This program is required by law to maintain the privacy of protected health information and to provide Patients/guardians with notice of its legal duties and Privacy practices with respect to protect health information.
2. This program is a student-oriented training program. The program does not submit information for insurance payment purposes. Payment is fee-for service only.
3. Since this program is a training program to educate future Dental Hygienist, your information may be used as educational material to benefit other students who have not directly participated in your direct care. If your protected health information is used, all reasonable efforts will be made to conceal your identity, including photographs. If your protected health information may reveal your identity, all reasonable efforts will be made to obtain your written consent to use such information.
4. The program may at times find it necessary to release all or portions of your protected health information to other healthcare workers without the Patient's/Guardian's written authorization. Examples of this release of information would include referrals to dentists for work to be performed, submissions of copies of x-rays made in our facility, physicians requests, or when required by law, or enforcement officials. Other uses and disclosures will be made only with the Patient's written authorization, and the Patient may revoke authorization at any time.
5. The program may disclose protected health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or other crime in order to avert a serious threat to your health or safety or the health or safety of others.
6. The program may contact the Patient/Guardian or the Patient's family members to provide appointment reminders, treatment(s) to be performed, treatment alternatives or other health related benefits and services that may be of interest to the patient and premedication reminders. In the event of an emergency, the program may disclose pertinent information to responding healthcare personnel. The program will use its professional judgment in disclosing only health information that is directly relevant to your care.
7. The program will use its professional judgment and its experience with common practice to make reasonable inferences of your best interest in allowing a person to pick-up prescriptions, medical/dental supplies, x-rays or other similar forms of health information.
8. The program reserves the right to change the terms of this notice. Any changes will be provided to the Patient /Guardian by copies of the revised Notice

THE PATIENT/GUARDIAN HAS THE FOLLOWING RIGHTS REGUARDING PROTECTED HEALTH INFORMATION:

1. The right to request restrictions on certain uses and disclosers of protected heath information.
2. The right to receive confidential communications of protected health information, as applicable.
3. The right to inspect and copy protected health information, as provided in the Privacy Regulation. The Patient/Guardian is responsible for costs to copy /duplicate such information.
4. The right to amend protected health information. The program reserves the right to refuse to amend protected health information if it determines such amendment is false or fraudulent.
5. The right to receive an accounting of disclosers of protected health information.
6. The right to obtain a paper copy of this notice upon request. This right extends to a

Patients may complain to the Program's HIPAA Privacy Officer or the Secretary of Health, and human Services without fear of retaliation by the program if they believe their privacy rights have been violated. Direct a written copy of the facts and allegations of your complaint to the HIPAA PRIVACY OFFICIER at the address below:

HIPAA Privacy
Officer Dept. of
Dental Hygiene
West Georgia Technical
College 4600 Timber Ridge
Dr Douglasville, GA 30135

Patient's Rights

In the West Georgia Technical College
Dental Hygiene Clinic

The patient can expect the following while receiving care at West Georgia Technical College Dental Hygiene Clinic.

1. Considerate, respectful and confidential treatment with the right to approve or refuse the release of their medical/dental records to any individual outside of the dental hygiene clinic facility.
2. Access to complete and current information about his/her condition and the right to participate in the planning of their dental hygiene care.
3. Advanced notice of the cost of their treatment
4. Advanced knowledge of the services that can be rendered in the Dental Hygiene Clinic
5. Compliance with the infection control guidelines recommended by the Centers for Disease Control and Occupational Safety and Health Administration
6. An explanation of recommended treatment, alternative treatment, the option to refuse treatment and the risk of no treatment
7. Treatment that meets the standard of preventative care in the profession
8. Referral information to take to a dentist for comprehensive dental care.