Patient: Please answer the following questions as completely and accurately as you can.

**Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

(First) (Last) (MI)

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title (Mr, Ms, Mrs, etc): \_\_\_\_\_\_\_Birthdate: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

Gender: □ Male □ Female □ Other Family status: □ Married □ Single □ Child □ Other

Race: □ American Indian/Alaska Native □ Asian or Pacific Islander □ Black/Non-Hispanic □ Hispanic □ White/Non-Hispanic □ Middle Eastern □ Other □ Prefer not to answer

Addressed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Cell phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_

Email (print clearly): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information**

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Medical Information**

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_

Date of last physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you in good health? (yes/no): \_\_\_\_\_\_\_\_\_\_\_

Are you under the care of your physician? (yes/no): \_\_\_\_\_\_\_\_ if yes describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Questions**

|  |  |
| --- | --- |
| Have you had any serious illness, operation, or been hospitalized in the past 5 years?  If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Yes □ No |
| Are you allergic or had any reactions to medications, drugs, local anesthetics, or other substances?  If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Yes □ No |
| **WOMEN**: Are you pregnant or think you may be pregnant? | □ Yes □ No |

**Medical Information**. Check the disease, condition, and/or treatment that you have now or have had in the past.

|  |  |  |
| --- | --- | --- |
| □ AIDS/HIV | □ Allergies | □ Anemia |
| □ Angina/Chest pain | □ Anxiety | □ Artificial Joint |
| □ Arthritis | □ Asthma | □ Bisphosphonate Tx |
| □ Bleeding disorder | □ Cancer | □ Cardiovascular Disease |
| □ Chemotherapy | □ Chronic Cough | □ Congenital Heart Disease |
| □ Diabetes | □ Eating Disorder | □ Emphysema |
| □ Epilepsy/Seizures | □ Fainting/Dizziness | □ Fever Blisters/Cold Sores/Herpes |
| □ Gastric Reflux | □ Glaucoma | □ Heart Disease |
| □ Heart Murmur | □ Heart Pacemaker | □ Hepatitis/Jaundice/Liver Disease |
| □ Hiatal Hernia | □ High/Low Blood Pressure | □ Indwelling Vein Catheter |
| □ Infective Endocarditis | □ Kidney/Renal Disease | □ Mental/Emotional Impairment |
| □ Mitral Valve Prolapse | □ Organ Transplant | □ Osteonecrosis of the Jaw |
| □ Pain in Jaw Joints | □ Physical Impairment (vision, hearing) | □ Prosthetic Implant |
| □ Respiratory | □ STD/VD | □ Stroke/TIA |
| □ Swollen Glands | □ Tuberculosis – Active | □ Unexplained Weight Change |
| □ Ulcers | □ Yellow Jaundice |  |
| □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ None |  |

Explain all checked responses here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Dental Information.** Check the disease, condition, and/or treatment that you have now or have had in the past.

|  |  |
| --- | --- |
| How long has it been since you have seen a dentist?  □ 6 mo–1 year □ 1-3 years □ 4-6 years □ 7+years |  |
| How long has it been since you have had your teeth cleaned?  □ 6 mo–1 year □ 1-3 years □ 4-6 years □ 7+years |  |
| What is your chief dental complaint? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| What are your sources of drinking water?  □ Bottle water □ Well water □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Do you expect to keep your teeth all your life? | □ Yes □ No |
| Do you chew or suck on hard candy, cough drops or mints or chew gum? | □ Yes □ No |
| Are you nervous about dental work or have had a bad experience with dental work? | □ Yes □ No |
| Do you play contact sports that require you to use a sports mouth guard? | □ Yes □ No |
| Do you use tobacco? Number of years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you interested in quitting? | □ Yes □ No  □ Yes □ No |
| Do you drink alcohol? | □ Yes □ No |

**Patient Medication Information.** Please list all medications you take with dosage and frequency.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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 the dentist, dental hygiene faculty, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

**Patient Signature** (if over the age of 18 and legally permitted to make health care decisions)

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient personal representative/Parent/Legal Guardian:** I certify that I have the legal authority under federal and state laws to sign this form on behalf of the patient identified below.

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Internal Dental Clinic Use Only

□ Form signed by patient, parent, legal guardian, or personal representative.

Witness Staff initials \_\_\_\_\_\_\_\_\_\_\_

**Patient Communication Consent**

As pursuant to the HIPAA Privacy and Security Rule, I consent to the following forms of communication.

□ Cell Phone

□ Home Phone

□ Text Messaging on cell phone: *patient is responsible for any messaging data rates that apply.*

□ Email

**Patient**

* HIPAA permits the Dallas College dental hygiene clinic to leave appointment reminders on answering machines and voicemail systems if you have consented to be contacted by phone. All messages will be limited to appointment specific information only.
* Dallas College will input your consented forms of communication into your electronic record and only contact you via the indicated forms of communication above.
* You reserve the right to change your communication consent preference at any time. A new form with your signature/date is needed prior to Dallas College making the change.

**Patient Signature** (if over the age of 18 and legally permitted to make health care decisions)

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient personal representative/Parent/Legal Guardian:** I certify that I have the legal authority under federal and state laws to sign this form on behalf of the patient identified below.

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Questions?** Please contact the Dallas College HIPAA Privacy Official Lisa Mayo, Academic Chair Dental Hygiene (214) 860-2375 Revised 7.20.23

**Consent for Treatment**

I, the undersigned, understand and consent to the following treatment at the Dallas College dental hygiene clinic:

* **Evaluation**: Screening of my oral health including oral cancer and periodontal assessment, diagnosis by a licensed dentist of my oral conditions and pathology, medical history, dental history, and social history review.
* **Radiological**: X-rays will be taken as part of the patient appointment as they are an integral part of oral health evaluation, diagnosis, and treatment planning. I understand I will not be accepted as a patient without consent for x-rays. If I provide current x-rays from my dental office that are of diagnostic quality, then this can be substituted for the x-rays the Dallas College dentist recommends. If the recommended x-rays are not included in the provided x-rays from my dental office, I will allow the clinic to take the missing x-rays.
* **Treatment**: I consent to allowing a student hygienist to perform all diagnosed dental hygiene procedures. All student hygienists work under the direct supervision of a licensed dental hygienist and dentist and all steps of appointments are evaluated by these licensed individuals.
* **Excluded Treatment**: I understand the Dallas College dental hygiene clinic only provides dental hygiene preventive services and any dental treatment needs I have beyond dental hygiene services will be referred to an outside the college dental provider. I understand regular visits with a dental practice is needed for optimal oral health.
* **Appointments**: Multiple appointments will be needed to complete my treatment as the Dallas College dental hygiene clinic is a teaching institution. I agree to attend all scheduled appointments for the length of time they are scheduled. Failure to comply with appointment standards may result in my dismissal from the dental hygiene clinic.

**Patient Signature** (if over the age of 18 and legally permitted to make health care decisions)

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient personal representative/Parent/Legal Guardian:** I certify that I have the legal authority under federal and state laws to sign this form on behalf of the patient identified below.

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Questions?** Please contact the Dallas College HIPAA Privacy Official Lisa Mayo, Academic Chair Dental Hygiene (214) 860-2375 Revised 7.20.23

**Bloodborne Pathogens Standard**

If a Dallas College employee or student is intentionally or unintentionally exposed to body fluids, bloodborne pathogen, or communicable disease through treatment rendered, both the individual and the source patient should be tested. The cost for testing rests with the patient and the exposed individual.

|  |
| --- |
| **Dallas College Bloodborne Pathogens Statement**  A work hazard of a clinically practicing dental professional treating live patients is the potential to be exposed to communicable diseases and bloodborne pathogens. Standard precautions represent a set of rules healthcare providers follow to protect themselves and their patients from pathogens spread by body fluids. Standard precautions aim to prevent the transmission of communicable and bloodborne pathogens through inhalation, direct contact, indirect contact, and sharps prevention. The Dallas College dental programs enforce and educate students and employees on healthcare standard precautions so they may safely treat patients and be knowledgeable of disease transmission risk.  The Dallas College dental programs follow current recommendations from the Center for Disease Control (CDC), National Institute for Occupational Safety and Health (NIOSH), Organization for Safety, Asepsis, and Prevention (OSAP), American Dental Association (ADA), and the American Dental Hygienists’ Association (ADHA) to protect all Dental Healthcare Personnel (DHCP).  Dallas College dental programs obey by the rules and regulations set forth by the Food and Drug Administration (FDA), Environmental Protection Agency (EPA), Texas Department of State Health Services, Occupational Safety and Health Administration (OSHA), and the Department of Health and Human Services as they pertain to communicable diseases and bloodborne pathogens.  The Dallas College dental programs are committed to ensuring that each employee, applicant, student, and patient is provided a safe and healthy environment. Dallas College requires all students and employees to have current immunizations, which include the Hepatitis B series, to protect themselves and patients from disease transmission. Dental professionals are ethically obligated to safeguard the confidentiality of patient records and to maintain those records in a manner consistent with the protection and welfare of the patient.  Dallas College emphasizes education for employees and students concerning communicable and bloodborne diseases and managing each case of disease transmission with sensitivity, flexibility, and concern for the individual. The districts’ decisions concerning a person who has a communicable disease shall be based on current and well-informed medical judgement which includes the nature of the disease, risk of transmission to others, symptoms, and special circumstances of the person, and balancing identifiable risks and available alternatives to respond to a student or employee with a communicable disease.  Employees and students are strongly encouraged to undergo personal evaluation to assess their own communicable disease status prior to enrollment. No student will be denied entry to a program, required to cease attending college, or participating in college functions solely based on diagnosis of a communicable or bloodborne disease. If a review of the facts demonstrates a student is unable to perform as required by the degree plan or presents a health risk to themselves or fellow community members, a decision shall be made regarding the student’s attendance at the college. Dallas College shall offer reasonable accommodations to both students and employees who are infected with a communicable disease. Generally, reasonable accommodations will not require expenditure of additional funds.  The Dallas College dental clinic has policies related specially to bloodborne and infectious diseases that include human immunodeficiency virus (HIV), hepatitis B (HBV), and other bloodborne infections.   * Persons who are seropositive for a bloodborne disease shall receive the same treatment as those who are seronegative. * Standard precautions are followed in the dental clinic to reduce the cycle of infection and eliminate cross-contamination, reduce the number of airborne pathogens, protect all patients and personnel from infection, and ensure the chain of infection is not broken. * A patient infected with a bloodborne pathogen should be treated with compassion and dignity and will be provided access to dental care and treatment within the scope of practice in the dental clinic. |

**Bloodborne Pathogens Standard cont’d**

**Patient**: I, the undersigned below, understand that in the event a Dallas College employee or student is exposed to my body fluids or blood during the course of treatment, my blood should be tested at my own expense with a special coded system to ensure my confidentiality. If such exposure occurs, I will receive additional information about testing protocols and dental hygiene clinic procedures. I will be given the right to decline testing. Any decision I make will not prejudice my patient relationship and standing with the Dallas College dental hygiene clinic.

**Patient Signature** (if over the age of 18 and legally permitted to make health care decisions)

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient personal representative/Parent/Legal Guardian:** I certify that I have the legal authority under federal and state laws to sign this form on behalf of the patient identified below.

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Questions?** Please contact the Dallas College HIPAA Privacy Official Lisa Mayo, Academic Chair Dental Hygiene (214) 860-2375 Revised 7.20.23

**Patient Bill of Rights**

Dallas College dental hygiene clinic is a teaching institution. All patients will receive high quality dental hygiene services at no charge if their treatment needs are within the scope of practice for the dental hygiene clinic and there is a student need. Student hygienists provide direct patient care under the direct supervision of a licensed dental hygienist and dentist.

**Services Available**

|  |  |  |
| --- | --- | --- |
| * Medical/Dental/Social History review * Vital signs * Oral Cancer Screening * Radiographs (X-rays) * Cleanings * Deep cleanings * Sealants | * Oral Health Education * Oral Hygiene Aids * Plaque Percentage * Periodontal Assessment * Fluoride * Application Desensitizing Agents * Laser Treatment | * Care of Dental Prosthesis * Nutritional Counseling * Smoking Cessation * Injectable and Non-Injectable Local Anesthesia * Locally Applied Antibiotics * Polish, Floss |

**Fees**

All above services are provided at no charge to all patients.

**Patient Rights**

* Record Request: Patients have the right to request a review or copy of their patient record under HIPAA and Texas Health & Safety Code 181.001 unless releasing the record would cause substantial and identifiable harm to the patient (mental health, mentally disables, alcohol or drug treatment programs). The Dallas College dental hygiene clinic will send a copy of patient records to a third party at the patient’s request. If I would like to exercise this right, you will request a ***record release form*** from the administrative staff of the Dallas College dental hygiene clinic. The dental hygiene clinic only releases records with a signed patient request and will provide patient information that is in a designated record set. The clinic does not charge a fee for the release of records. Per Texas Health & Safety Code 181.001 HB300, the clinic has 15 days to act on the release of records request which begins when the clinic receives the request.
* All patients will be treated with compassionate and confidential care.
* All treatment rendered is prescribed by a licensed dentist and student hygienists are supervised directly by licensed dental hygienists and dentists.
* You will be given an opportunity to ask questions throughout your appointments.
* You will be provided with an explanation of treatment recommendations, treatment alternatives, the option to refuse treatment and the risks associated with this decision will be discussed with an opportunity for you to ask questions.
* You will be asked to consent to treatment in a written format.
* You will be informed if your treatment needs exceed the scope of practice of the Dallas College dental hygiene clinic. You will be provided a referral with a list of dental providers for treatment services not provided by the dental hygiene clinic.
* You have the right to complain to the HIPAA Privacy Official noted at the bottom of this form. If I would like to exercise this right, you will request a ***complaint form*** from the administrative staff of the Dallas College dental hygiene clinic.

**Patient Expectations**

Patient: Please read through the below information and sign the bottom of the form if you agree to the patient rights and expectations listed.

* **Appointments**: I will attend all scheduled appointments for the length of time they are scheduled. I will attend multiple appointments needed to complete my treatment. I will arrive on time for my appointments. I will provide **48-hours** notice if I need to reschedule my appointment.
* **Minors**: I will not bring minor children with me to my appointment. Children may not be left unattended in the patient waiting room. Children are not allowed in the dental clinic treatment room unless they are the patient.
* **Medical Consultation**: I understand that a medical consultation from my health care provider may be needed prior to receiving treatment at the dental hygiene clinic. This decision will be made by the licensed dentist on staff at Dallas College and explained to me during my appointment.
* **Behavior**: I will be respectful and considerate of all Dallas College dental hygiene employees and students. I understand this is a teaching institution and that students may need more time to render services than a private practice licensed provider. I will not harass, make disparaging comments, suggestive actions, uninvited physical contact, or unpleasant verbal comments to anyone while on a Dallas College campus. Any unbecoming behavior will result in my dismissal as a patient from the dental hygiene clinic and I will be provided a referral with a list of dental providers who can continue my treatment.

Thank you for your contribution to our student learning. Your attendance is valuable, and we appreciate your support. Please do not provide gifts to Dallas College employees or students.

**Patient Signature** (if over the age of 18 and legally permitted to make health care decisions)

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient personal representative/Parent/Legal Guardian:** I certify that I have the legal authority under federal and state laws to sign this form on behalf of the patient identified below.

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Questions?** Please contact the Dallas College HIPAA Privacy Official Lisa Mayo, Academic Chair Dental Hygiene (214) 860-2375 Revised 7.20.23

**Notice of Privacy Practices (NPP)**

This notice describes how patient health information is used and disclosed by the Dallas College dental hygiene clinic and how a patient can gain access to this information. Please review and read carefully.

The Dallas College dental hygiene clinic is required by law (Health Insurance Portability and Accountability Act and Texas HB300) to maintain the privacy of patient protected health information (PHI), to provide notice with our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this NPP while it is in effect. This NPP takes effect on July 20, 2023, and will remain in effect until it is replaced at a future date.

The Dallas College dental hygiene clinic reserves the right to change the NPP and the terms of the NPP at any time, provided such changes are permitted by federal and state laws, and to make new NPP provisions effective for all PHI that we maintain. When a change to the NPP occurs, we will change the postings in the clinic, provide a copy to any patient who requests it, and change our NPP on the dental hygiene clinic website.

You may request a copy of this NPP at any time and will be provided a copy the same day. You will be asked to sign this NPP on your first appointment and your signed document will be good for **6 years**. This form is compliant with **HIPAA and Texas Health & Safety Code 181.001**.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose your health information for different purposes, including treatment and health care operations. For each of these categories, we have provided a description and example. Some information, such as HIV-related information, genetic information, alcohol/substance use/abuse, and mental health records may be entitled to special confidentiality protection under applicable federal or state law. We abide by these special protections as they pertain to applicable cases.

|  |  |
| --- | --- |
| **Treatment**  We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist proving your treatment.  **Healthcare Operations**  We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assurance and improvement activities, conducting training programs, and licensing activities. Patient identifiable data is not used in these operations.  **Individuals Involved in Your Care**  We may disclose your health information to your family or friends, patient representative, or any other individual identified by you when they are involved in your care. If a person has the authority by law to make health decision for you, we will treat that patient representative the same way we would treat you with respect to your health information.  **Disaster Relief**  We may use or disclose your health information to assist in disaster relief efforts.  **Required by Law**  We may use or disclose your health information when we are required to do so by law.  **National Security**  We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official’s health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of the PHI of an inmate or patient.  **Secretary of HHS**  We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.  **Coroners, Medical Examiners, Funeral Directors**  We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties. | **Public Health Activities**  We may disclose your health information for public health activities, including disclosures to: Prevent or control disease, injury, or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of products or devices; Notify a person who may have been exposed to a disease or condition; Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.  **Workers Compensation**  We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs established by law.  **Law Enforcement**  We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.  **Health Oversight Activities**  We may disclose PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.  **Judicial and Administrative Proceedings**  If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made by either the requesting party or us to tell you about the request or to obtain an order protecting the information requested.  **Research**  We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your information. If private patient information would be used in the research, this is only done upon patient written consent. |
| **YOUR HEALTH INFORMATION RIGHTS**  **Access**  You have the right to look at or obtain copies of your health information with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this NPP. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you requested if readily producible. We do not charge for this service. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.  **Disclosure Accounting**  With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing.  **Right to Request a Restriction**  You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both, (3) to who you want the limits to apply. We are not required to agree to your request.  **Alternative Communication**  You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location. We will accommodate all reasonable requests. Requests that would endanger or increase the risk to an employee or student will not be approved. Requests that violate Dallas College policies will not be approved.  **Amendment**  You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you as such. If we deny your request for an amendment, we will provide you with a written explanation of the denial and your rights.  **Right to Notification of a Breach**  You will receive notification of a breach to your unsecured PHI as required by HIPAA law.  **Electronic Notice**  You will receive a paper copy of this NPP upon your request even if you have agreed to receive this NPP electronically. | **OTHER USES AND DISCLOSURES OF PHI**  Your authorization is required by HIPPA, with few exceptions, for disclosure of psychotherapy notes, use of disclosure of PHI for marketing and fundraising, and for the sale of PHI. Dallas College does not participate in the marketing, fundraising, or sale activities that would require the release of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for use in this NPP (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we still stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.  **QUESTIONS AND COMPLAINTS**  If you want more information about our privacy practices or have questions or concerns, please contact us.  If you are concerned we have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communication with you by alternative means or at alternative locations, you may complain using the contact information listed at the end of this NPP. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon your request. |

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Patient Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient, Legal guardian, or Personal representative signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (circle one): Self Parent/Guardian Personal Representative

Internal Dental Clinic Use Only

□ Form signed by patient, legal guardian, personal rep. □ Form signature refused. I explained the NPP and attempted to obtain a signature. The reason provided for the rejection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff initials \_\_\_\_\_\_\_\_\_

**Questions?** Please contact the Dallas College HIPAA Privacy Official Lisa Mayo, Academic Chair Dental Hygiene (214) 860-2375 Revised 7.20.23