Patient Approval Forms

2010 Alabama Dental Hygiene Licensure Exam

June 21 - 22, 2010

THIS FORM MUST BE COMPLETED IN EVERY DETAIL PRIOR TO PATIENT APPROVAL

PATIENT DISCLAIMER, CONSENT AND RELEASE

I, the undersigned, for and in consideration of the free dental work to be performed for and upon me, and my desire to assist candidates for the dental hygiene licensure examination, I hereby volunteer to be a dental patient for a candidate taking the Board of Dental Examiners of Alabama (Board) dental hygiene license examination (examination) scheduled on June 21-22, 2010 at University of Alabama at Birmingham, School of Dentistry (School of Dentistry).

I understand and agree that it is the policy of the Board to conduct the examination of Dental Hygiene candidates in a manner so as to provide total anonymity to both candidate and patient and to do so assigns a unique number to each candidate for each and all procedures conducted. I understand and agree in furtherance of that policy the name of the Dental Hygiene candidate will not appear on this Disclaimer, Consent and Release and only the unique number assigned to the Dental Hygiene candidate is to be used in this document.

I understand that while I am a dental patient at this examination the herein identified candidate may conduct and perform various procedures on me all to which I consent.

Patient's Signature _____Date of Birth _____
Candidate ID# _____

Parent/Guardian's Signature
(if patient is a minor) _____

Name(print)_____StreetAddress_____

City _____ State _____Zip_____ Date _____

The nature and effect of the procedures to be performed and the risks involved have been explained to me. No guarantee or assurance has been given by anyone as to the results which may be obtained.

I am aware and understand that the candidates who will perform dental work for and upon me may not be presently licensed to practice dental hygiene and that; therefore, no licensing entity has yet made the determination as to whether the candidate possesses the requisite education, training, competence and skill of a duly licensed dental hygienist. I understand and agree that no representations or warranties are being made or extended by the Board, its members, agents, employees, representatives, any examiner duly appointed by the Board or any individuals assisting the Board regarding the character, training, education, competency or professional skill possessed by any candidate to perform any of the dental procedures to which I am voluntarily submitting.

I understand and agree that all of the dental procedures will be performed in locations under the control of the School of Dentistry, no dental procedures will be performed by any faculty member of the School of Dentistry and that no faculty member of the School of Dentistry will be present during the performance of the dental procedures for which I am volunteering to be a patient. The School of Dentistry does not warrant or guarantee the procedures or services performed. I specifically release the School of Dentistry, its faculty, staff employees and agents from any and all claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses and compensation whatsoever arising out of or in connection with the clinical dental procedures to be performed upon me by the candidate.

I understand and agree that intra-oral photographs will be taken of the procedures performed by the candidate.

I understand and agree the procedures to be performed, as a part of this examination, may not constitute full and comprehensive dental care and treatment and that there may be other procedures and treatment that I may need but will not be performed as a part of the examination requirements. I further agree that the School of Dentistry and the Board of Dental Examiners of Alabama are not responsible for providing me with any remedial or follow up treatment for any procedures to be performed on me by the candidate.

With full knowledge and understanding of the above conditions and any risk which may be involved, I hereby release the Board of Dental Examiners of Alabama, its members, employees, agents, representatives, any examiner duly appointed by the Board and any individuals assisting the Board from any and all claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses, fees and compensation whatsoever which I now have or may have, whether directly or indirectly, in connection with or relating to the dental procedures to be performed upon me by the candidate during the dental hygiene licensure examination.

I acknowledge and agree that my name will not be identified or listed in connection with any procedure performed and with that understanding, I further authorize the dental hygiene candidate to release any and all of my records, reports, information, intra-oral photographs and/or dental radiographs required for or utilized in the

examination or in connection with any procedures performed on me and any other information that he/she may possess to the Board of Dental Examiners of Alabama for its use in assessing the results of the examination.

Witness signature _____ Name (print) _____

Street Address _____ City _____

State _____Zip_____ Date _____

Any person other than the candidate may serve as a witness

The Health Insurance Portability and Accountability Act of 1996 (Act) and the Rules promulgated by the Department of Health and Human Services pursuant to the Act permits disclosure of otherwise protected health information as defined in 45 C.F.R. 160.103 a 'health oversight agency' without the written authorization of the individual as described in 45 C.F.R. 164.508 or the opportunity for the individual to agree or object as described in 45 C.F.R. 164.510. See 45 C.F.R. 164.512 (d) (1). Specifically, this rule provides as follows:

A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative or criminal proceedings or actions; or other activities necessary for appropriate oversight of:
The health care system;

(i) Government benefit programs for which health information is relevant to beneficiary eligibility;
(ii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or
(iii) Entities subject to civil rights laws for which health information is necessary for determining compliance."

A health oversight agency is defined in 45 C.F.R. § 164.501 as follows:

Health oversight agency means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe or a person or entity acting under a grant authority from a contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.
Since the Board of Dental Examiners of Alabama is a health oversight agency which is authorized by law to seek this information pursuant to the Alabama Dental Practice Act, the disclosure of the requested information is permitted and does not implicate the Act or its rules."

HEALTH HISTORY
(Complete prior to patient approval)

Please circle Y (for yes) or N (for no) All **YES** answers require a comment.

	YES/NO		YES/NO
A. Presently under physicians care	_____	L. Allergies (food or drug)	_____
B. Hospitalization (last five years)	_____	M. Taking medication	_____
C. Recent illnesses	_____	N. Dietary restrictions	_____
D. Heart disease	_____	O. Are you pregnant	_____?
E. High blood pressure	_____	P. Epilepsy	_____
F. Bleeding problems	_____	Q. Venereal disease	_____
G. Blood disease	_____	R. Radiation exposure	_____
H. Rheumatic fever	_____	S. AIDS	_____
I. Diabetes	_____	T. Kidney disorders	_____
J. Liver disorders	_____	U. Respiratory problem	_____
K. Tuberculosis	_____		

Blood Pressure _____ **Pulse** _____

ADDITIONAL COMMENTS:

_____

_____

_____

(Complete prior to patient approval)

Pre-operative full mouth radiographic series; mount provided;
Candidate ID assigned at final registration

RADIOGRAPHIC STATEMENT

I CERTIFY THAT BOARD CANDIDATE ID #_____ (TO BE COMPLETED BY CANDIDATE AFTER REGISTRATION) HAS PERSONALLY EXPOSED AND MOUNTED THE REQUIRED RADIOGRAPHS FOR THE ALABAMA DENTAL HYGIENE BOARDS.

DENTIST SIGNATURE

_____
_____

FACULTY PERSON OR DENTIST IN CHARGE OF RADIOGRAPHIC EQUIPMENT:

_____
_____
(PLEASE SIGN)

PATIENT'S NAME _____

DATE_____

1. Pre-operative full mouth series required for patient approval
2. The required (or comparable) radiographic mount supplied during application process
3. This form is to be completed at the time the radiographs are exposed.
4. Candidate number will not be entered until Final Registration June 2010

PERIODONTAL HISTORY/TREATMENT PLAN

(Complete prior to patient approval)

CANDIDATE'S # _____ EXAMINATION DATE _____

PRINT LEGIBLY

APPROXIMATE DATE OF LAST DENTAL APPOINTMENT: _____

NATURE OF TREATMENT: _____

CHIEF COMPLAINT: _____

HEAD AND NECK INSPECTION (describe normal findings):

EXTRAORAL: _____

INTRAORAL: _____

MUCOSA _____

GINGIVA _____

TEETH _____

OCCLUSION _____

ORAL HABITS _____

PAROTID _____

SUMMARY: _____

_____

_____

DESCRIPTION OF PERIODONTAL CONDITION: _____

_____

_____

SIGNIFICANCE OF MEDICAL HISTORY IN PATIENT MANAGEMENT: _____

_____

_____

PERIODONTAL TREATMENT PLAN: _____

_____

_____

PROGNOSIS: _____

_____

_____

_____

_____