2016 Dental Candidate Packet

This packet includes the following forms:

- Chairside Assistant Form
- Medical History Form
- Post-Operative Care Agreement
- Patient Consent, Disclosure & Assumption of Responsibility
- Periodontal Treatment Selection Worksheet (Optional. Use only if taking the Periodontal section)
If you are using a chairside dental assistant during the SRTA Patient Treatment Clinical Examinations you must complete this form. Attach a photograph of your assistant in the two designated areas on this form. This must be presented to the Forms Desk the day of the examination; otherwise, you will not be permitted to utilize a chairside assistant.

Assistant Name: ____________________________
Assistant Address: ____________________________
Assistant Telephone: ____________________________

I affirm that the person listed above will act as a chairside assistant for the examination:
Exam Site: ____________________________
Candidate Sequential: ____________________________

I further affirm that the assistant is adequately knowledgeable about infection control and dental procedures so as not to cause harm to the patient or other personnel with whom the assistant may come in contact with.

For the Restorative Procedures, I affirm that said chairside assistant is not a dentist (licensed or unlicensed), junior/senior dental student or dental laboratory technician. I understand that I may use a dental assistant, dental hygienist or first/second year dental student.

For the Periodontal Procedure, I affirm that said chairside assistant is not a dentist (licensed or unlicensed), junior/senior dental student or dental hygienist (licensed or unlicensed), final year dental hygiene student or dental laboratory technician. I understand that I may use a dental assistant or first/second year dental student.

I affirm that the chairside assistant will wear proper attire and the photo identification badge at all times while assisting me.

I understand that I am responsible for any and all actions and behavior of the chairside assistant that may violate the examination policy of the SRTA Examination.

As the chairside assistant, I affirm that I will maintain the anonymity of all candidates and examiners that I may encounter.

I understand that as a chairside assistant, I am not to enter the scoring area at any time prior to, during and following the published times of the examination.

I understand that failure to comply with any of the aforementioned articles will result in the candidates’ dismissal from and failure of the examination. Additional penalties may also include restrictions on the candidates’ ability to sit for future examinations.

By signing below, I acknowledge that all infractions will be reported to the State Boards of Dentistry.

This agreement (with the attached photo of the assistant) will be held by the Clinic Floor Coordinator on-site and will be sent to the SRTA Office when the Examination is complete.

Signature of Candidate ____________________________ Date _____________
Signature of Assistant ____________________________ Date _____________

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Patient Name: ________________________________
Birthdate: ________________________________
Weight: ________________________________
Date Form Completed: ________________________________

Candidate Seq. Number: ________________________________
Cubicle Number: ________________________________

INSTRUCTIONS TO PATIENT:
Answer the following questions as completely and accurately as possible. All Information is CONFIDENTIAL. Please circle “Y” for Yes or “N” for No to all questions, and write your answers as appropriate.

1. **Y** N Are you under the care of a physician at this time? If yes, for what condition? ________________________________

2. The name, address and telephone number of my physician is: _______________________________________________________

3. My last complete physical examination was: ___________________________________________________________________

4. **Y** N Have you been hospitalized or have a serious illness or skin condition with the last five years?
   If yes, please specify: _______________________________________________________________________________________

5. **Y** N Are you allergic to or had any adverse reaction to any medicine, drugs, local anesthetics, LATEX or other substances?
   If yes, please specify: _______________________________________________________________________________________

6. **Y** N Do you now or have you ever smoked cigarettes or used tobacco products?
   If yes, please specify: Number of packs/day: ______ Number of years: ______

7. A. **Y** N Heart Attack
   Date: ______

   B. **Y** N Heart Surgery
   Date: ______

   C. **Y** N Stroke
   Date: ______

   D. **Y** N Artificial/prosthetic heart valves
   Date: ______

   E. **Y** N Artificial/prosthetic joint replacement (knee or hip)
   Date: ______

   F. **Y** N Arteriosclerosis/coronary occlusion

   G. **Y** N Angina/cheast pain, shortness of breath

   H. **Y** N High blood pressure

   I. **Y** N Valve damage following heart transplant

   J. **Y** N Infective endocarditis (heart infection)

   K. **Y** N Congenital heart disease

   L. **Y** N Congestive heart failure

   M. **Y** N Pacemaker

   N. **Y** N Implanted cardio-defibrillator

   O. **Y** N Abnormal bleeding bruise or history of transfusion. Taking aspirin or blood thinner?

   P. **Y** N Lung/ respiratory condition (asthma, bronchitis, emphysema)

   Q. **Y** N Tuberculosis or pertussis

   R. **Y** N Diabetes

   S. **Y** N Epilepsy/seizures/convulsions

   T. **Y** N Emotional/mental health disorder (anxiety, depression, bipolar)

   U. **Y** N Liver disease (hepatitis A, B or C/jaundice/cirrhosis)

   V. **Y** N Kidney/renal disease

   W. **Y** N Thyroid disease

   X. **Y** N Cancer/chemo/radiation therapy

   Y. **Y** N Sexually transmitted disease(s)

   Z. **Y** N HIV positive/AIDS

   AA. **Y** N Immune suppression or immune deficiency

   BB. **Y** N Alcohol abuse (alcohol rehabilitation)

   CC. **Y** N Drug abuse (coca methamphetamines, heroin, crack) or drug rehabilitation

   DD. **Y** N Have you been diagnosed with MRSA?

EXPLANATION FOR YES ANSWERS IN QUESTION 8
9. Y N Have you had surgery or x-ray treatment for a tumor, growth or other condition of your head or neck?
   If yes, please list:________________________________________________________________________________________

10. Y N Do you have any other diseases, conditions, or problems that have not been listed?
    If yes, please explain:_______________________________________________________________________________________

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<thead>
<tr>
<th>OTHER CONDITION</th>
<th>EXPLANATION</th>
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11. Y N Are you taking or have you ever taken any medications, (examples below), either orally or by injection, for osteoporosis, osteopenia or bone loss due to aging OR lung cancer, breast cancer, prostate cancer, colorectal cancer, wet macular degeneration, Paget’s Disease, or multiple myeloma?

Examples: Fosamax® (alendronate); Boniva® (ibandronate); Actonel® (risedronate); Reclast® yearly injection (zoledronic acid); Aredia® (pamidronate); Zometa® (zoledronic acid); Bonefos® (clodronate); Avastin® (bevacizumab); Erbitux® (cetuximab); Herceptin® (trastuzumab)?

12. Y N Please list any pre-medication, medications, pills, or drugs with dosage which you are taking both prescription and nonprescription. (Must be completed the DAY OF THE EXAMINATION)

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>REASON PRESCRIBED</th>
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13. WOMEN ONLY

Y N Are you pregnant or is there any possibility that you might be pregnant? If yes, when is your expected due date? ____________________________

Y N Are you currently breast feeding?

____________________________________________________________________________________________________________________________________________________

AMERICAN SOCIETY OF ANESTHESIOLOGY (ASA CLASSIFICATION)

ASA I: Normal health patient

ASA II: Patient with mild systemic disease; no function limitation – e.g., smoker with well controlled hypertension

ASA III: Patient with severe systemic disease; definite functional impairment – e.g., diabetes mellitus (DM) and angina pectoris with relatively stable disease, but requiring therapy

DENTAL CANDIDATES: Any item on the Medical History with a YES response in questions #4-13 could require a medical clearance from a licensed physician if the explanation section indicates the possibility of a significant systemic condition that could affect the patient’s suitability for elective dental treatment during the examination. The medical clearance must include the physician’s name, address, and phone number, Attach letter to this form to turn in on the day of the exam.

I certify that I have read and understand the information above. I acknowledge that I have answered these questions accurately and completely. I will not hold the testing agency responsible for any action taken or not taken because of errors I may have made when completing this form.

__________________________________________________________
Patient Signature

__________________________________________________________
Date

__________________________________________________________
Candidate Sequential Number & Initials

__________________________________________________________
Date

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A separate form must be completed for each patient treated during the examination.

**Candidate Information**
- Candidate Seq. Number: __________________________
- Examination Site: __________________________
- Examination Date: __________________________

**Procedure**
- □ Restorative
- □ Periodontal
- □ Dental Hygiene

**Patient Information**
- Name (Print): __________________________
- Address: __________________________
- Today's Date: __________________________
- City, State, Zip Code: __________________________

The SRTA Examination is the process for determining if a Dentist has the minimal practical skills necessary to obtain a license to practice Dentistry; therefore, no guarantee can be made that the work performed will be adequate. If you feel you may need additional care as a result of the work performed during the examination, you should visit a licensed Dentist. You may visit a Dentist of your choosing or you may use the referral listed below. **(Note to Candidate: Please complete only one of the sections – A, B, or C – listed in item I. A signature is required under item II – Patient Acceptance.)**

**I. Acceptance of Responsibility for Post-Operative Care**

- □ A. The patient is a “patient of record” at the Dental School and will provide post-operative care as necessary according to the guidelines of the School of Dentistry.

  Signature of Authorized School Official __________________________
  Date __________________________

- □ B. This is to confirm my willingness to provide any post operative care required related to treatment rendered on the SRTA dental examination. It is understood that this agreement expires sixty days following the examination.

  Name __________________________
  License # __________________________
  Telephone # __________________________
  Address __________________________
  City, State, Zip Code __________________________

  Signature of Provider __________________________
  Date __________________________

- □ C. I will choose my own Dentist if post-operative care is necessary.

  Name of Provider __________________________
  Date __________________________

**Reason for Post-Operative Care:**

_________________________________________________________________________________

II. **Patient Acceptance – I understand and agree to the following:**

- Additional treatment related to services rendered during this examination may be required
- Post operative arrangements specified above
- There may be a fee involved in the post operative care and I hereby release SRTA and associated testing agencies, and the School of Dentistry where the examination was held from any financial obligation
- The provider listed above has no obligation to provide care if not initiated within sixty (60) days of the examination

  Patient Signature __________________________
  Date __________________________
  Patient Telephone # __________________________

  Legal guardian or Parent Signature (If patient is minor) __________________________
  Date __________________________
  CFC Pin __________________________
I authorize the individual listed below (the "Candidate") to perform the following dental procedure(s) during the administration by the testing agency (SRTA) of a dental licensing examination (the "Examination"):

- [ ] Posterior Amalgam Prep & Restoration
- [ ] Posterior Composite Prep & Restoration
- [ ] Anterior Composite Prep & Restoration
- [ ] Periodontal Treatment

Acknowledgement
I understand the following:
- the Candidate may not be a licensed dentist. (Cross through this line if the Candidate is a licensed dentist.)
- any arrangements between the Candidate and me regarding my serving as a patient (including any financial arrangements) are solely between the Candidate and me, and do not involve the testing agency in any way.
- the testing agency has no knowledge of the Candidate’s skill or competence, and makes no promises about them.
- the testing agency has no duty to, and will not, notify me of inadequate work done by the Candidate during the Examination.
- it is my responsibility to have any and all dental work performed by the Candidate checked by a licensed dentist to determine that it is satisfactory.

Disclosure of Risks
The Candidate has explained to me the risks involved in the procedures the Candidate will perform on me. The nature and purpose of the dental procedure(s), as well as the risks and possible complications, have been explained to me to my satisfaction by the Candidate. My questions with regard to the dental procedure(s) have been answered.

Adequacy of Treatment
I understand that the treatment provided during the Examination does not necessarily fulfill all my oral health needs, may not be performed correctly, or may not represent my entire treatment plan, and that further treatment may be necessary. I have been informed of the availability of services to complete treatment.

Authorization of Disclosure of Medical Information
I recognize that medical information which could be pertinent to the oral health care I receive in the course of the Examination may be communicated to the testing agency, their examiners, the staff and clinicians of the dental school where the Examination is located, and any other medical professionals when deemed medically necessary, or when necessary for the administration for the Examination. I authorize this disclosure. This authorization specifically includes the disclosure of radiographs (X-rays), and information about my current medical and dental condition and my prior medical and dental history.

Medical Condition and Medications
I have fully disclosed my current medical conditions and medical history to the best of my knowledge. I understand that if I am taking medications that are associated with certain chronic conditions, I may not be accepted as a patient for the Examination. I have fully disclosed all medications that I am currently taking. I have been informed that patients who are taking bisphosphonate medications may be at risk of osteonecrosis of the jaw after dental treatment or as a result of dental infections. I understand that neither the testing agency nor the school assumes any responsibility or liability regarding the health status of patients or candidates. As neither the candidate nor patient is considered an employee of the testing agency or school, OSHA regulations do not apply. If an exposure to blood borne agents such as HIV or hepatitis or other infectious conditions occurs, it is not the responsibility of the testing agency or school to provide serologic testing, counseling, follow up care or any other health service.

Consent to X-rays and Photographs
I consent to the taking of appropriate radiographs (X-rays) and the examination of my teeth gums. I also consent to having testing agency examiners or the staff and clinicians of the dental school take photographs of my teeth and gums for use in future examinations, provided that my name is not in any way associated with the photographs or X-rays.

Anesthesia
I understand that as part of the dental procedure(s), it may be necessary to administer local anesthetics and I consent to the use of anesthetics by the Candidate.

Agreement
I release the SRTA, participating dental schools, and their employees and/or agents from any and all responsibility or liability of any nature whatsoever for their acts, and any acts of the Candidate (including negligence), which occur during the course of this Examination, and any damages or injuries I may suffer as a result of my participation in the Examination.

I verify that I am not a dentist (licensed or unlicensed), a dental student in the 3rd or 4th or final year of dental school, or a dental hygiene student in the final year of school.

By my signature below, I verify that I have read and fully understood the above information, and I agree to the terms of this agreement.

Patient Signature

Date

Candidate Sequential Number & Initials

Date

NOTE: This form will be used by examiners during the procedure(s) – candidates should initial, but NOT sign in order to preserve anonymity.
**Subgingival Calculus Detection**

You are allowed to use only 6 to 8 teeth, but twelve surfaces must be indicated. In the box to the left, enter tooth number. Record the tooth numbers in ascending order using the 1 to 32 system. In the adjacent box, indicate the surface on the tooth where you have selected to remove the calculus (M=Mesial, F=Facial, D=Distal, L=Lingual). If more than one surface is selected on the same tooth, enter tooth number each time a new surface is listed, example:

<table>
<thead>
<tr>
<th>Tooth</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>M</td>
</tr>
<tr>
<td>3</td>
<td>D</td>
</tr>
</tbody>
</table>

You must select one molar and at least two more molars and/or premolars. All posterior teeth must have at least one approximating tooth within 2 mm distance. No more than 4 surfaces may be selected on incisors. **At least 3 surfaces must be on interproximal surfaces of molars and/or premolars.**

**Pocket Depth Qualification**

From the Subgingival Calculus Detection list above, select 3 separate teeth with 4 mm or deeper pockets. Enter the tooth number in the box to the left. Indicate the surface where the selected pocket is located in the adjacent box (M=Mesial, F=Facial, D=Distal, L=Lingual). It is not necessary to select one of these surfaces to scale.

**Plaque/Stain Removal**

Enter the first 6 separate teeth from the Subgingival Calculus Detection list above. These teeth will be evaluated for the removal of plaque, stain, and supragingival calculus on the crowns of the teeth.

*It is the candidate's responsibility to accurately transfer the information from this Treatment Selection Worksheet to the electronic Evaluation Form prior to presenting the patient for assignment.*

*Each time the patient is sent to the Evaluation Station, the Periodontal Progress Form, Medical History, Informed Consent and radiographs must accompany the patient.*

*The Forms Desk will insert Start and Finish times on the Periodontal Progress Form upon check out.*