2019 Dental Hygiene Forms

This packet includes the following documents:

1. Form for Online Orientation Slides
2. Health History Form
3. Patient Disclaimer, Consent & Release Form
4. Postoperative Care Agreement Form (Minimum of 2 copies)
5. Incident Disclaimer Form
6. Dental Hygiene Clinical Periodontal Charting Form
7. Dental Hygiene Clinical Procedure Form
8. Administration of Anesthesia Form (Only needed if a Dentist or Licensed Practitioner is administering your LA)
9. Examination Site Letter (This can be found under 'Documents' on your SRTA profile)

Exam Site: _____

Southern Regional Testing Agency, Inc.

Online Notice Form - Orientation Slides

This signed notice must be presented during registration. The on-line presentation provides details on the requirements for registration and orientation. For your benefit, we strongly suggest you view this presentation.

By signing below, I confirm that I reviewed and understand the online orientation presentation prior to the scheduled registration and examination.

Print Name Candidate #

Signature Date

CANDIDATE #: _____ CUBICLE #: _____

SRTA Dental Hygiene Examination: Patient Medical History

** Will this patient be shared with another candidate today? Yes☐ No☐ Sharing patient with Candidate # _____

Patient's Name: _____ Date Form Completed: _____

Birthdate:_____ Weight:_____

Blood Pressure:_____ **Date/Time Taken:** _____
Required – Must Be Taken Day of Examination CFM Confirms BP Taken Day of Exam

CFM PIN _____

INSTRUCTIONS TO PATIENT:

Answer the following questions as completely and accurately as possible. All Information is CONFIDENTIAL. Please circle "YES" or "NO" to all questions, and write in your answers as appropriate.

1. YES NO 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 on _____
4. YES NO Has a physician treated you in the past six months?
   If yes, for what condition? _____
5. YES NO Have you been hospitalized or have a serious illness or skin condition within the last five years?
   If yes, please specify: _____
6. YES NO Are you allergic or had any adverse reaction to any medicine, drugs, local anesthetics, LATEX or other substances?
   If yes, please specify: _____
7. YES NO Do you now or have you ever smoked cigarettes or used tobacco products?
   If yes, please specify: Number of packs/day:_____ Number of years:_____
8. Do you have or have you had any of the following diseases/problems? Please explain "YES" answers below. "Yes" answers in the shaded area require a written letter from the patient's physician giving permission to participate in this examination.

If YES, MD written clearance required

A.	**YES**	**NO**	Angina/chest pain, shortness of breath	**Q.**	**YES**	**NO**	Hives, itching, or skin rash
B.	**YES**	**NO**	Heart attack Date: _____	**R.**	**YES**	**NO**	Sexually transmitted disease(s)
C.	**YES**	**NO**	Heart surgery Date: _____	**S.**	**YES**	**NO**	Stomach or duodenal ulcers
D.	**YES**	**NO**	Stroke Date: _____	**T.**	**YES**	**NO**	Thyroid disease
E.	**YES**	**NO**	Congestive heart failure	**U.**	**YES**	**NO**	Tuberculosis or pertussis
F.	**YES**	**NO**	Coronary artery or other heart disease	**V.**	**YES**	**NO**	HIV positive/AIDS
G.	**YES**	**NO**	Arteriosclerosis/coronary occlusion	**W.**	**YES**	**NO**	Congenital heart disease
H.	**YES**	**NO**	Epilepsy/seizures/convulsions	**X.**	**YES**	**NO**	Pacemaker
I.	**YES**	**NO**	Valve damage following heart transplant	**Y.**	**YES**	**NO**	Cancer/chemo/radiation therapy
J.	**YES**	**NO**	Infective endocarditis (heart infection)	**Z.**	**YES**	**NO**	Implanted cardio-defibrillator
K.	**YES**	**NO**	Kidney/renal disease	**AA.**	**YES**	**NO**	Immune suppression or deficiency
L.	**YES**	**NO**	Abnormal bleeding, bruise or history of transfusion. Taking aspirin or blood thinner?	**BB.**	**YES**	**NO**	Artificial/prosthetic joint replacement (knee or hip) Date:_____
M.	**YES**	**NO**	Lung/respiratory condition (asthma, bronchitis, emphysema)	**CC.**	**YES**	**NO**	Artificial/prosthetic heart valves Date: _____
N.	**YES**	**NO**	Diabetes	**DD.**	**YES**	**NO**	Alcohol abuse (alcohol rehabilitation)
O.	**YES**	**NO**	Emotional/mental health disorder (anxiety, depression, bipolar)	**EE.**	**YES**	**NO**	Drug abuse (cocaine methamphetamines, heroin, crack) or drug rehabilitation
P.	**YES**	**NO**	Liver disease (hepatitis A, B or C/jaundice/cirrhosis)	**FF.**	**YES**	**NO**	High blood pressure

LETTER	EXPLANATION FOR "YES" ANSWERS IN QUESTION 8

TURN PAGE OVER ⇨

9. YES NO 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. YES NO Do you have any other diseases, conditions, or problems that have not been listed? If yes, please explain:

OTHER CONDITION	EXPLANATION

11. YES NO Are you taking or have you even 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)?

If yes, please list the appropriate medication(s) below:

_____

_____

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

MEDICATION	REASON PRESCRIBED
1.	
2.	
3.	
4.	
5.	

13. **WOMEN ONLY**

YES NO Are you pregnant or is there any possibility that you might be pregnant?

If yes, when is your expected due date?_____

YES NO Are you currently breast feeding?

AMERICAN SOCIETY OF ANESTHESIOLOGY (ASA) CLASSIFICATION

ASA I: Normal health patient

ASA II: Patient with mild systemic disease; no functional 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

CLASS

DENTAL HYGIENE CANDIDATES: Any item on the Medical History with a "YES" response, in questions #8A THROUGH #8K require a medical clearance from a licensed physician. 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 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 Initials Only Date

SRTA
Assessment

Patient Consent, Disclosure, & Assumption of Responsibility

I authorize the individual referenced below (the "Candidate") to perform the following dental procedure(s) during the administration by the testing agency (SRTA) of a dental licensing examination or dental hygiene examination (the "Examination"):

☐ **Posterior Amalgam Prep & Restoration**

☐ **Posterior Composite Prep & Restoration**

☐ **Anterior Composite Prep & Restoration**

☐ **Periodontal Treatment**

☐ **Partial Oral Prophylaxis and Periodontal Scaling- Dental Hygiene**

Acknowledgement

I understand the following:

- the Candidate may not be licensed to perform the above services (the "Services"). **(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.
- I hereby consent to having the Candidate perform each of the Services.

Disclosure of Risks

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

Adequacy of Treatment

I understand that the Services 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.

No Treatment by SRTA or School

I understand that SRTA will not be performing any diagnosis or treatment of me. Further, I understand that all the procedures will be performed in spaces under the control of the School but that faculty members, officers, employees and agents of the school will not be present during the performance of the Services. I hereby release the School, its faculty, staff, employees and agents from any and all claims, causes of actions, demands, rights and damages whatsoever arising out of or in connection with the Services performed by the Candidate.

TURN PAGE OVER ⇨

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. I further consent to disclosure of any information concerning my medical information by SRTA, so long as my name is not associated with the information.

Medical Condition and Medications

I have fully disclosed my current medical conditions and medical history to the best of my knowledge and all medications I am taking. I have been informed that patients who are taking bisphosphonate medications may be as 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 training and 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.

Assumption of Risk and Release

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, 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 hereby voluntarily assume all risks relating to the Services and the examination, including the risk of injury, loss of teeth and/or death.

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 procedures.

Candidates should initial, NOT sign in order to preserve anonymity.

SRTA | Post-Operative Care Agreement

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
- ☐ Day 1
- ☐ Day 2

Patient Information

Name (Print): _____ Address: _____

Today's Date: City, State, Zip Code: _____

The SRTA Examination is the process for determining if a Dentist/Dental Hygienist has the minimal practical skills necessary to obtain a license to practice Dentistry/Dental Hygiene; 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/Dental Hygienist. You may visit a Dentist/Dental Hygienist 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/Dental Hygiene.

_____ _____

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/dental hygiene 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/Dental Hygienist 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/Dental Hygiene 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

Exam Site_____

INCIDENT DISCLAIMER

DISCLOSURE STATEMENT AND EXPRESS ASSUMPTION OF RISK FOR ANY DAMAGE FROM (1) EXPOSURE TO BLOODBORNE INFECTIOUS AGENTS SUCH AS HIV, HBV, AND OTHER MICROORGANISMS IN THE BLOOD, (2) EXPOSURE TO ORAL OR RESPIRATORY SECRETIONS,(3) OTHER INJURIES.

The relationship between the Southern Regional Testing Agency (SRTA), the school where the examination is administered ("the school") and you (the candidate or patient) is not an employer/employee relationship. Neither SRTA nor the examination site is responsible for your behavior. As a candidate or patient, you do not qualify as an employee and are not covered under OSHA regulations. You must assume responsibility for any exposure or other incident which may occur.

SRTA and the school cannot, and therefore, do not assume any responsibility or liability for the health status of candidates assistants or patients. If an exposure or other injury occurs during the course of this examination, neither SRTA nor the school assumes any duty or responsibility to you to provide serologic testing, counseling, follow-up care or any other health service. It is your responsibility to assure that you see a licensed health care professional and initiate appropriate management and follow-up care.

LIMITATION OF LIABILITY AND INDEMNITY AGREEMENT

I, the undersigned, state that I have read and understood the above disclosure statement and express assumption of risk. I agree that SRTA and the school are not responsible for the prevention or management of any of the incidents listed above. I agree to release and discharge SRTA for any liability or personal injury which may occur to me, unless actively committed by SRTA . I agree to release and discharge the school for any liability or injury that may occur to me unless actively committed by school personnel. I further understand that SRTA and the school have no responsibility or duty to provide medical evaluation treatment, counseling, follow-up care, or any type of compensation for any of the incidents listed above. I also agree to indemnify and hold SRTA and the school harmless for any occurrence under this agreement, including SRTA's and the school's attorneys' fees, costs and expenses, should a claim be made against them.

Candidate: Printed Name & Candidate SEQ #	Patient: Printed Name
Candidate: Signature	Patient: Signature
Candidate: Date Signed	Patient: Date Signed

CANDIDATE # CUBICLE #

DENTAL CHARTING FORM

SECTION 1. GENERAL INFORMATION:

Patient Name: Examination Site: Date:

Will this patient be shared with another candidate today? Yes☐ No☐ Sharing patient with Candidate # _____

SECTION 2: MEDICAL CLEARANCE: Examiner Use Only: CFM PIN _____ (Pt. is cleared for treatment)

CFM: List any relevant health issues _____

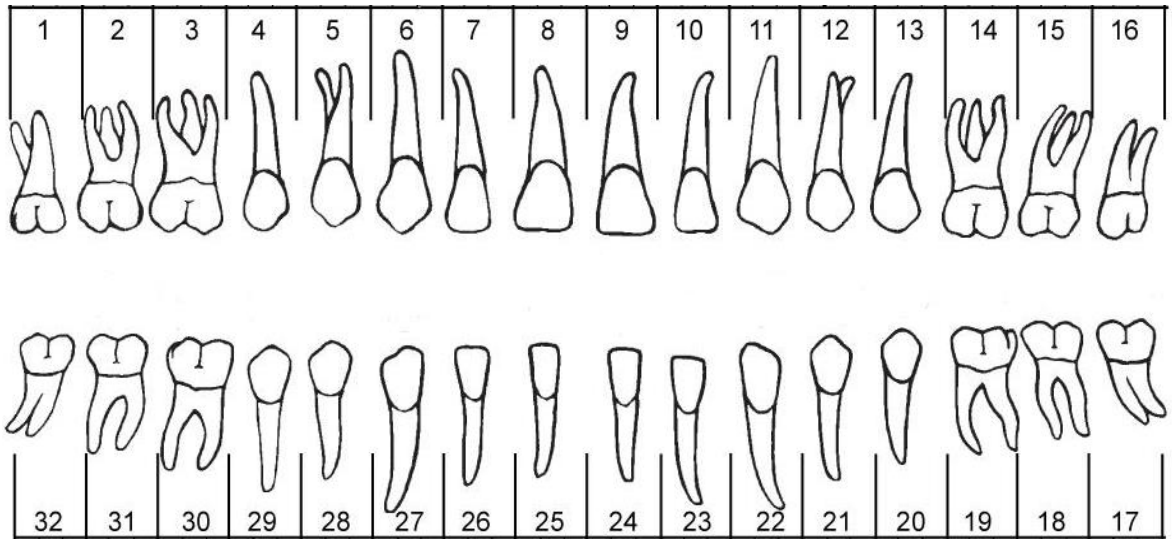
SECTION 3: SELECTION OF TEETH FOR CALCULUS REMOVAL:

Primary Quadrant Submission		Secondary Quadrant Submission	
Circle primary quadrant: UR UL LR LL	Include this quadrant's 3rd molar? Circle "Yes" or "No" Yes No	Circle secondary quadrant: UR UL LR LL	Include this quadrant's 3rd molar? Circle "Yes" or "No" Yes No

SECTION 4: CANDIDATE COMMENTS TO EXAMINERS:

SECTION 5. DENTAL CHARTING: Prior to the examination chart the following items:

Missing teeth- Cross (X) out entire tooth area
Implants- Cross (X) through tooth and change the tooth number to "I"
Impacted/Unerupted- Circle the entire tooth, root, and tooth number
Partially erupted- Replace the tooth # with "PE"
Deciduous tooth- Replace the tooth # with the tooth letter
Retained root tip- Cross (X) through the crown, circle the root, and replace the tooth # with "RT"
Permanent bridge pontic- Cross (X) through tooth and change tooth number to "



SECTION 6: EXAMINERS COMMENTS: For examiner use only. Candidates do not write in this section.

Please enter PIN after comments.

CANDIDATE #: **CUBICLE #**

DENTAL HYGIENE PROCEDURE FORM

SECTION 1: GENERAL INFORMATION:

Exam Site: Date: Will this patient be shared with another candidate today? Yes☐ No☐

Sharing patient with Candidate # _____

SECTION 2: MEDICAL CLEARANCE: Examiner Use Only: CFM PIN_____ (Pt. is cleared for treatment)

SECTION 3: SELECTION OF TEETH FOR CALCULUS REMOVAL:

Primary Quadrant Submission		**Secondary Quadrant Submission**	
Circle primary quadrant: UR UL LR LL	Include this quadrant's 3rd molar? Circle "Yes" or "No" Yes No	Circle secondary quadrant: UR UL LR LL	Include this quadrant's 3rd molar? Circle "Yes" or "No" Yes No

SECTION 4: SELECTION ASSIGNMENT: Examiner Use Only: DO NOT WRITE IN THIS SECTION.
After check-in, the final assignment is entered here by the examiners. All surfaces of all teeth in this assignment must be free of remaining calculus, plaque, and stain for the final evaluation phase of the examination. No other areas of the patient's mouth will be evaluated.

Quadrant to treat: **Additional teeth to treat:**

SECTION 5: ANESTHESIA RECORD: Complete **all** information **except** quantity prior to check-in.

Type(s) of injections planned: _____ Name of anesthetic & vasoconstrictor: _____

Quantity (# of carpules/cartridges administered; complete after **all** injections given): _____

Candidate **number** OR signature of qualified practitioner_____

SECTION 6: PERIODONTAL ASSESSMENT: Do not complete this section until after check-in. Enter the probing depth in millimeters for the teeth surfaces assigned in this section.

Posterior tooth #_____: ML_____ L_____ DL_____ Anterior tooth #_____: ML_____ L_____ DL_____

SECTION 7: CALCULUS DETECTION: Do not complete this section until after check-in.
Is any type of calculus present? Circle either "Yes" or "No" for the three surfaces of each tooth assigned below.

Tooth#_____: **Mesial**: Yes No **Distal**: Yes No **Facial**: Yes No **Lingual**: Yes No

Tooth#_____: **Mesial**: Yes No **Distal**: Yes No **Facial**: Yes No **Lingual**: Yes No

Tooth#_____: **Mesial**: Yes No **Distal**: Yes No **Facial**: Yes No **Lingual**: Yes No

DISCLAIMER FOR LICENSED PRACTITIONER ADMINISTERING LOCAL ANESTHESIA

This form is also used as verification that SRTA has received your qualifications and that you understand the protocol of administering anesthesia in the state where the examination is being given. Please complete the form and return it to the candidate for presentation at registration the day of the examination.

DISCLOSURE STATEMENT AND EXPRESS ASSUMPTION OF RISK FOR ANY DAMAGE FROM (1) EXPOURE TO BLOOD BORNE INFECTIOUS AGENTS SUCH AS HIV, HBV, HCV AND OTHER MICROORGANISMA IN THE BLOOD, (2) EXPOSURE TO ORAL OR RESPIRATIORY SECRETIONS, (3) OTHER INJURIES.

SRTA is not responsible for your behavior as a professional. You must assume responsibility for any exposure or other incident which may occur.

SRTA and the school cannot, and therefore do not assume any responsibility or liability for the health status of practitioners or patients. If an exposure or other injury occurs during the course of this examination, neither SRTA nor the school assumes any duty or responsibility to you to provide serologic testing, counseling, follow up care or any other health service. It is your responsibility to see a licensed health care professional and initiate appropriate management and follow up care.

LIMITATION OF LIABILITY AND INDEMNITY AGREEMENT

I, the undersigned, state that I have read and understood the above disclosure statement and express assumption of risk. I agree that SRTA and the school are not responsible for the prevention or management of any of the incidents listed above. I agree to release and discharge SRTA and the school from any liability or damage which may occur to myself, unless expressly committee by SRTA or school personnel. I further understand that SRTA and the school have no responsibility or duty or provide medical evaluation, treatment, counseling, follow up care, or any type of compensation for any of the incidents listed above. I also agree to indemnify and hold SRTA and the school harmless for any occurrence under this agreement, including SRTA's and the school's attorneys' fees, costs and expenses, should a claim be made against them.

I have read the disclosure agreement, understand its contents, and agree to be bound by it.

Dated this _____ day of _____, 20___.

_____ _____

Licensed Practitioner Southern Regional Testing Agency, Inc. Representative

ADMINISTRATION OF ANESTHESIA BY A LICENSED PRACTIONER

EXAMINATION LOCATION _____ EXAMINATION DATE_____

I, _____, accept responsibility for the anesthesia related emergencies and anesthesia related postoperative complications affecting the patients to whom I have administered anesthesia. I am aware that it is recommended that I remain in the examination site during the candidates' treatment of the patient and that I give the patient information on how to contact me, if necessary, after the exam.

I will be administering anesthesia to the patients of the following candidate(s) (use back of this form if space is needed):

PRINT NAME _____ PHONE # _____

ADDRESS _____ STATE _____ ZIP_____

YOU MUST ALSO PROVIDE ON THE DAY OF THE EXAM:

1. **PHOTO ID**
2. **COPY OF DENTAL OR DENTAL HYGIENE LICENSE FROM THE STAT WHERE THE EXAM IS HELD**
3. **COPY OF LOCAL ANESTHESIA PERMIT FROM STAT WHERE THE EXAM IS HELD, IF YOU ARE A DENTAL HYGIENIST**
4. **COPY OF VERIFICATION OF CURRENT LIABILITY INSURANCE.**