CENTRAL CAROLINA COMMUNITY COLLEGE

_____
Driver's License or Picture ID #

Central Carolina Dental Program
Keller Health Sciences Building
1815 Nash Street
Sanford, NC 27330

Phone: (919) 777-7780
Fax: (919) 777-7788
Email: dentalprograms@cccc.edu

Please Print All Information:

Name of Patient:_____ _____ _____
(First Name) (Initial) (Last Name)

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced

Surname: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Date of Birth:_____Age:_____Ethnic Origin:_____

Home Address:_____

_____ _____ _____
(City) (State) (Zip Code)

Home Phone:_____ Cell Phone:_____

I Consent to the person listed below to obtain information for me in reference to my dental care:

Phone:_____Name:_____Relationship:_____

In Case of Emergency Please Call:

1. Phone:_____Name:_____Relationship:_____

2. Phone:_____Name:_____Relationship:_____

Date:_____ Signature:_____
(Patient or Legal Guardian

Central Carolina Community College

This form contains eight pages total, each page has a signature and dateline.

Dental Hygiene Program

Consent and Agreement

Please read the following information carefully. Signing this document means that you understand this agreement, that you consent to the terms of this agreement, and that ALL of your questions regarding this consent and agreement have been answered to your satisfaction.

**** PLEASE NOTE: CURRENTLY, THERE ARE NO CHARGES OR FEES FOR SUPPLIES AND TREATMENTS AS STATED IN # 6 BELOW****

After you have read this Consent and Agreement, please sign your name below indicating acceptance of the terms of this agreement.

1. As a consenting adult, I agree to permit the students, faculty and staff of the Central Carolina Community College Dental Hygiene Program to provide dental care to myself, child or legal ward as applicable.
2. I understand that all persons cannot be accepted as patients of the Central Carolina Community College Dental Hygiene Program. Persons with complicating medical conditions, rigid time requirements, and extremely difficult dental care needs may not be accepted. As a patient of the Central Carolina Community College Dental Hygiene Program, I understand that receiving dental hygiene care does not guarantee future dental treatment.
3. I understand that as a patient of the Central Carolina Community College Dental Hygiene Program, students of the Program under the direct supervision of clinical faculty will provide all treatment.
4. I understand that care at the Dental Hygiene Clinic takes longer than in a private dental practice. I also understand that appointments may be up to four hours long and that I must be prepared for multiple visits to complete my dental care needs or those of my child or legal ward.
5. I understand the Central Carolina Community College Dental Hygiene Program maintains the right to discontinue treatment for any appropriate reason such as, excessive cancellations. In such cases, the patient or parent/guardian agrees to accept full responsibility for pursuing alternate professional dental care. A letter will be sent informing the patient or parent/guardian that treatment is being discontinued. All records pertaining to the treatment and diagnosis of patients are the property of Central Carolina Community College Dental Hygiene Program. Records and x-rays will be duplicated upon written request.
6. ** I understand that I will be expected to pay for the treatment I receive and that Central Carolina Community College Dental Hygiene Program reserves the right to revise fees at any time, for any treatment which has not yet been started. During the course of my dental care unforeseen complications or new conditions may arise that may result in higher cost. Furthermore, I understand that in the event my treatment becomes too complex for a dental hygiene student to manage, it may be necessary for me to be referred to a private practice or clinic in order for me to receive the care I need. Should this occur, I understand that I will need to seek additional care off-campus. **
7. I understand that all dental procedures have certain risks, including possible side effects from some medicines used in dentistry and that these risks include but are not limited to:
   a) Allergic reactions
   b) Cuts / Abrasions
   c) Tenderness / Bruising from injections
   d) Sensitive teeth
8. I understand that by accepting treatment at Central Carolina Community College Dental Hygiene Program I also consent to future recall appointments for the purpose of assessing the quality and longevity of the dental treatment provided to me, my child or my legal ward.

Central Carolina Community College Dental Hygiene Program is hereby authorized to use any treatment records, x-rays, or photographs for teaching or research purposes, including their use in scientific journals. Patients' names will not be used or disclosed in connection with such use.

By signing below, I am indicating that I understand the terms of the consent agreement, and that I have the legal authority to give this consent of the patient, (if not myself). I hereby give consent to the Central Carolina Community College Dental Hygiene Program to perform those tasks, including local anesthesia, necessary or appropriate for proper dental examination, diagnosis, and treatment.

All of my questions regarding this consent and agreement have been answered. I have been provided a copy of this agreement for my reference.

_____ _____

Signature of Patient/Parent or Legal Guardian Date

Central Carolina Dental Center

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HIPAA
Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosures of my protected health information by the Central Carolina Dental Center for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Central Carolina Dental Center. My "protected health information" means medical, billing and demographic information about me collected from me and created or received by the Central Carolina Dental Center for treatment, payment and health care operations. **I understand that diagnosis or treatment of me by the Central Carolina Dental Center may be conditioned upon my consent as evidenced by my signature on this document.**

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Central Carolina Dental Center is not required to agree to the restrictions that may request. However, if Central Carolina Dental Center agrees to a restriction that I request, the restriction is binding on the Central Carolina Dental Center.

I have the right to revoke this consent, in writing, at any time. The revocation will be effective upon receipt, except to the extent that Central Carolina Dental Center has taken action in reliance on this consent.

I understand I have a right to review Central Carolina Dental Center's Notice of Privacy Practices prior to signing this document. Central Carolina Dental Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Central Carolina Dental Center. The Notice of Privacy Practices for Central Carolina Dental Center is also provided on the Central Carolina Community College Dental Programs website under patient admissions at www.cccc.edu. This Notice of Privacy Practices also describes my rights and Central Carolina Dental Center's duties with respect to my protected health information.

Central Carolina Dental Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Central Carolina Community College website, calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

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Central Carolina Community College
Dental Programs
1815 Nash Street
Sanford, NC 27330

Dear Patient,

It is the goal of CCCC dental programs to serve the community while giving our students meaningful clinical experiences that will allow them to join the dental workforce and continue to serve the community. In order to achieve this goal, CCCC dental program has instituted the following cancellation policy:

- If you fail to make a scheduled appointment and/or cancel with less than 24 hours notice, we will not be able to schedule you another appointment for six (6) months.

- If you fail to make a scheduled appointment and/or cancel with less than 24 hours notice for a second time, we will not be able to reschedule you another appointment for one (1) year.

- If you fail and/or cancel an appointment with less than 24 hours notice for a third time or if you have missed three appointments with more than 24 hours notice within a six (6) month period, we will be unable to make any appointments for you in the future.

If you have questions regarding this policy, please call the office number above.

Sincerely,
CCCC Dental Programs

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

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Scope of Comprehensive Dental Hygiene Care

You have been screened and classified for treatment in the Dental Hygiene Clinic by a dental hygiene student. During the course of your dental hygiene treatment, you will be advised as to your future dental needs. Comprehensive dental hygiene treatment will be completed, unless otherwise specified during the screening or treatment planning process. However, since we are authorized to provide only dental hygiene services, **we can make no guarantee that all your dental treatment will be completed at the School.** You will be referred to a private practice dentist or a public health clinic for any additional care deemed necessary.

Items included within the scope of **comprehensive dental hygiene care** in the state of North Carolina that may also be experienced here at the School clinic include:

1. Complete oral prophylaxis including preventive homecare instructions.
2. Application of preventive agents to oral structures.
3. Exposure and processing of radiographs.
4. Administration of medicaments prescribed by a licensed dentist.
5. Preparation of diagnostic aids.
6. Written records of oral conditions for interpretation by the dentist.

Additional functions may be performed as deemed appropriate during the treatment planning process. These functions, listed below, will be performed on an ***as needed basis*** for an individual patient:

1. Taking impressions for study models and opposing casts.
2. Sealant application.
3. Removal of excess cement.
4. Application of desensitizing solutions.
5. Performance of periodontal screening and probing.
6. Subgingival exploration for or removal of hard or soft deposits.
7. Sulcular irrigation.
8. Application of resorbable sulcular antimicrobial or antibiotic agents.
9. Extra-oral adjustments of temporary restorations or appliances.

Signature of Patient/Parent or Legal Guardian	**Date**

Central Carolina Community College
Dental Hygiene Program

PATIENT RIGHTS AND RESPONSIBILITIES

Central Carolina Community College Dental Programs is a teaching institution with a commitment to the education of health care professionals. Adults and children who receive care in our clinical programs are vitally important participants in this process. For that reason, we expect to make your experience a healthy and satisfying one.

We are committed to the highest quality of care. To do this, the patient or parents of the patients, and dental professionals must work together to develop the best relationships. A better understanding of your oral condition and your rights and responsibilities in the treatment of that condition will contribute to better care and greater satisfaction for all concerned. We realize that no set of guidelines can ever fully describe the special relationship that exists between you and your student dental hygiene provider. The purpose of this brochure is to enhance the mutual trust, cooperation, and respect which surround that relationship.

YOUR RIGHTS AS A PATIENT

YOU AS A PERSON – We are not only interested in providing you with dental hygiene services, but also in recognizing and respecting your dignity as a human being. You may expect to be treated with consideration and respect regardless of your race, creed, national origin, age, handicap, or sex.

SERVICES YOU NEED –We will inform you about what we can and cannot provide and help in making referrals for treatment elsewhere. You will also be informed of the need for and availability of appointments. When your relationship with the school ends, for whatever reason, we will tell you about your further treatment needs.

UNDERSTANDING YOUR PLAN OF CARE – You are entitled to a clear explanation of your dental problems, what treatment is recommended, what the alternatives are as well as any risks involved, who will provide your care, and approximately how long it may take. Complications encountered during therapy that may alter your plan of care or affect the outcome of your treatment will also be explained to you. If you are receiving dental hygiene services from our school, you can expect at least one recall appointment a few months after treatment is completed. This is our way of assuring that treatment is rendered at the dental hygiene school in a satisfactory manner, and to see if further care is needed.

CONSENT AND REFUSAL OF TREATMENT – You have the right to participate in decisions about your dental treatment and to have any questions answered before making a decision. Any treatment you receive will meet appropriate standards of care. You may also refuse treatment and expect to be informed of the possible consequences of your decision. If your refusal is not congruent with good standards of care, it may be left to your discretion to seek treatment outside the Dental Hygiene Clinic, and you could be considered for dismissal as a patient.

CONFIDENTIALITY – Discussions about your care will be done with as much consideration for your privacy as possible. A copy of your treatment record will not be released without your written permission, except as required through an insurance contract or by law.

_____ _____

Signature of Patient/Parent or Legal Guardian **Date**

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YOUR RESPONSIBILITIES AS A PATIENT

As a patient or the parent of a patient in our program, your responsibilities are:

To share honestly and completely information about your medical and dental history, previous illnesses, hospitalizations, exposure to communicable diseases, information about medications you are taking, allergies, and your current medical care.

To let us know when there are changes in your general health condition, or if you should experience complications or unusual discomfort following a treatment procedure.

To ask questions so that you can better understand the nature of your dental condition and the treatment provided.

To follow the instructions you are given, be available for services you need, and keep your scheduled appointments.

To be available at least one-half-day a week, starting at either 9:00 a.m. for a morning appointment or 1:00 p.m. for an afternoon appointment; and if you are the parent of a patient under the age of 18, to be available during the entire treatment appointment.

To give at least 24 hours notice when canceling an appointment.

To be prompt in attendance for you, or your child's dental visit.

To seek routine care from another source (such as a dentist in private practice), once the course of prescribed treatment and recall are complete. You may, of course, seek dental hygiene treatment if the schools schedule allows.

To be considerate and respectful of other patients, and of students, faculty and staff of Central Carolina Community College.

If you have any questions, concerns or problems with your treatment, please call (919) 777-7780, Monday through Thursday, from 8:00 a.m. to 4:00 p.m.

_____ _____

Signature of Patient/Parent or Legal Guardian **Date**

Rev. 09/19

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I reviewed a copy of Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

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