2981206019

DENTAL
PERIODONTAL PROGRESS FORM

CANDIDATE IDENTIFICATION NUMBER

INFORMATION ONLY

Candidate # **Unit #**

Finish Time: :

ANESTHETIC RECORD

Type(s) of Injection: ☐ Infiltration ☐ Block

Anesthetic(s)

Vasoconstrictor: ☐ None ☐ 1:50,000 ☐ 1:100,000

Quantity (cc.) ☐ 1.8 cc ☐ 3.6 cc

No Anesthetic Being Administered: ☐

Initial Anesthetic Approval — **EXAMINER #**

Additional Anesthetic Approval
(For one carpule ONLY) — **EXAMINER #**

Patient Approved for Dismissal:

CFE#

Patient's Name:

Assistant's Name:

PRETREATMENT MEDICATION (If Required)

Medication(s) (Brand/Generic Name)

Dosage/When Taken

CLINIC FLOOR PATIENT APPROVAL

Patient Acceptability

- ☐ Completed Medical Health History Form
- ☐ Acceptable Oral and Systemic Conditions
- ☐ Completed Treatment Consent Form
- ☐ Completed Treatment Selection Form
- ☐ Acceptable Radiographs
- ☐ 11/12 ODU Explorer
- ☐ PCV-12 HuFriedy Periodontal Probe

ACCEPTABLE for Treatment:

EXAMINER #

CLINIC FLOOR PATIENT REJECTION

Patient Rejection

- ☐ Incomplete Medical Health History Form
- ☐ Unacceptable Oral and Systemic Conditions
- ☐ Incomplete Treatment Consent Form
- ☐ Treatment Selection
- ☐ Radiographs
- ☐ Incorrect Instruments or No Instruments

NOT ACCEPTABLE for Treatment:

EXAMINER # EXAMINER #

GRADING ROOM STATION

First Trip
Treatment Selection

- Extra/Intra Oral Assessment
- Calculus Detection
- Pocket Depth Measurement Assignment

Second Trip
Treatment Evaluation

- Calculus Removal
- Supragingival/Stain
- Tissue Management
- Pocket Depth Measurements

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PERIODONTAL TREATMENT CONSENT FORM

INFORMATION ONLY

I, ____, authorize Candidate #________, a dental
(Patient's Name)
examination candidate, to perform upon myself the following dental procedure(s):

a) Patient Assessment (Medical Health History, Intra/Extra Oral Assessment)

b) Periodontal Scaling as required for examination

c) Plaque/Stain Removal, Periodontal Measurements

d) Radiographs as required for examination

I understand that the candidate may not be a licensed dentist. I further understand that such procedure(s) will be performed by the candidate as part of an examination conducted to determine the qualification of the candidate for licensure. 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 examiners.

The nature and purpose of the procedure(s) as well as the risks and possible complications have been explained to me. My questions with regard to the procedure(s) have been answered. I acknowledge that no guarantee or warranty has been made as to the results to be obtained. I understand that only a portion of my mouth will receive dental treatment today and that further treatment for that portion and/or the remainder of my mouth may be necessary. I have been informed of the availability of services to complete any services which may require follow-up care.

I further understand that the CITA Board exam is totally separate from the School of Dentistry even though the exam takes place in the school's clinics. Payment arrangements, future treatment promises, or any other agreement that I make with my candidate is not the responsibility of the School of Dentistry. The candidate may arrange for me to be an alternate patient. If the candidate does not elect to treat me during the exam, my dental needs may be treated at the school later; however, at the School's usual and customary fees.

DATED this _____________ day of _________, 20 _________.

____ (   ) __________________________
Patient's Signature   Patient's Phone Number

____
Patient's Address   City   State   Zip Code

____
Parent or Guardian's Signature (if patient is a minor)

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MEDICAL HEALTH HISTORY FORM

INFORMATION ONLY

Patient Name: ______________________________

Birthdate: ______________ Weight: ______________ Date Form Completed: ______________

Blood Pressure on day of exam (right arm sitting): ______________

<u>INSTRUCTIONS TO THE PATIENT:</u> 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. Are you under the care of a physician at this time? YES NO
   If yes, for what condition? ______________________________

2. Has a physician treated you in the past six months? YES NO
   If yes, for what condition? ______________________________

3. Are you allergic to any medicines, drugs, latex or other substances? YES NO
   If so, please specify: ______________________________

4. Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or Adipex (phentermine)? YES NO
   If so, please list: ______________________________

5. Do you have or have you had any of the following diseases/problems?

A.	Abnormal bleeding	YES	NO	K.	Rheumatic Heart Disease	YES	NO
B.	Asthma	YES	NO	L.	High blood pressure	YES	NO
C.	Heart Condition	YES	NO	M.	Diabetes (list type)	YES	NO
D.	Heart Valves-Damaged or Replaced	YES	NO	N.	Active Tuberculosis	YES	NO
E.	Heart attack	YES	NO	O.	Kidney/renal disease	YES	NO
F .	Heart murmur	YES	NO	P.	Hepatitis/jaundice (list type)	YES	NO
G.	Inborn heart defects	YES	NO	Q.	Epilepsy/seizures	YES	NO
H.	Infective Endocarditis	YES	NO	R.	Joint replacement	YES	NO
I.	Mitral valve prolapse	YES	NO	S.	Stroke	YES	NO
J.	Unshielded pacemaker	YES	NO	T.	Thyroid problems	YES	NO
U.	Cancer/chemotherapy/radiation	YES	NO				

   Please explain any YES answers: ______________________________

6. Do you have any disease, condition, or problem not listed above that would pose a significant risk to the health or safety of yourself or others during the performance of dental procedures? YES NO If yes, please explain.
   ____

*7. There are some drugs that interact with local anesthetics and can put you at risk. Please list any **premedication, medications, pills, or drugs** which you are currently taking-both prescription and nonprescription-especially anything you have consumed within the last 24 hours.
   ____

8. Have you ever taken drugs such as Boniva or Fosamax for Osteoporosis? YES NO If yes, please explain.
   ____

WOMEN ONLY: Are you pregnant? **YES** **NO** If yes, what is the expected due date? ______________

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 CITA responsible for any action taken or not taken because of errors I may have made when completing this form.

____

PATIENT SIGNATURE **DATE SIGNED**

All items marked with an asterisk must be completed the DAY OF THE EXAMINATION!