

WELCOME TO OXFORD COLLEGE OF ARTS, BUSINESS AND TECHNOLOGY

Date: 06/20/2023
ID#: _____

MEDICAL ALERT MARKED IN RED ONLY

Medical Alert

Yes ☐ No ☐

Diabetes, Hypertension, Premedication, Hyper/Hypoglycemia, Hyperlipidemia, Blood Disorders, Hepatitis, Seizure Disorder, Allergies, Hypertension, Epi-Pen

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. Please answer the questions as accurately as you can. If you have any questions of doubt, please ask the treating dentist or our student, who is available to assist you with the completion of this form. All information is **strictly confidential** and will remain in this office. PLEASE PRINT.

REGISTRATION INFORMATION FILLED OUT BY PT ONLY

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other ☐ Preferred Pronoun: _____

Name: _____
Last Name First Name Middle Initial

Address: _____
Street Apt. # City Province

Home Phone: () _____ Bus. Phone: () _____ May we call _____

Birth Date: Mo. _____ Day _____ Year _____ Age _____ Gender _____ Email Address _____

Marital Status: _____ Employer: _____ Occupation _____

Whom may we thank for referring you? _____

Relative ☐ Friend of Student ☐

MEDICAL PRIORITY FILLED OUT BY DH WITH PT CHAIRSIDE

Family Physician: _____
Name Address Postal Code
Phone #: _____ Fax #: _____ Email Address: _____

Are you under the care of a Medical Specialist? Yes ☐ No ☐ Type of Specialist: _____

Specialist: _____
Name Address Postal Code Phone #: _____

In case of emergency, please contact _____
Name and Relation Phone #: _____

Primary Care Dentist: _____
Name Address Postal Code
Phone #: _____ Fax #: _____ Email Address: _____

DENTAL HISTORY Please ☒ Yes or No to each question. If unsure of a question, please consult with the student. Yes No

1. Is there a dental problem you would like treated immediately? ☐ ☐

2. Date of your last dental cleaning: Month, Year Last visit: Cleaning? Checkup Last x-rays: Date? FMS? Panorex?

3. Have you been seeing a dentist regularly? IF NO, WHY? EX. FINANCIAL REASONS? ☐ ☐

4. Have you ever had any of the following

Periodontal treatment (treatment of the gums)? WHAT TX, WHEN, WHERE IN ORAL CAVITY ☐ ☐

Orthodontic treatment (to straighten or realign teeth)? ... WHAT TX, WHEN EX. BRACES, INVISALIGN HERBST ☐ ☐

A bite plate or any other appliance (dentures)? IDENTIFY TX, WHEN? ☐ ☐

Oral surgery (surgery of the mouth/jaw joint or implant surgery in one or both of your jaws)? WHAT, WHEN, WHERE IN OC .. ☐ ☐

If you answered YES to the last question, who performed the surgery?..... IDENTIFY SPECIALIST OR DENTIST ☐ ☐

When was it done? _____ Are you being followed up by a dental specialist?..... ☐ ☐

5. Are there any growth spots or sore spots in your mouth? IF YES, WHERE IN OC AND ASK PT IF THEY USED ANYTHING TO TREAT ☐ ☐

6. Do your gums bleed when brushing or eating or do you suffer from pain or swelling in your gums?..... HOW OFTEN? ☐ ☐

8. Does food catch between your teeth?..... WHERE? AND HOW OFTEN? ☐ ☐

9. Are any of you teeth sensitive to heat cold, sweets, or pressure?..... WHERE? AND HOW OFTEN ☐ ☐

10. Have you been advised to take antibiotics before a dental appointment?..... IF YES, WHAT ANTIBIOTICS AND HOW LONG ☐ ☐

11. Do you use dental floss, proxabrush or stimulants? How often? EX. FLOSS 2X PER DAY ☐ ☐

12. How often do you brush your teeth? EX. 2X PER DAY ☐ ☐

13. Do you feel you have bad breath?..... ☐ ☐

Appointment 1 Goals:

- Review the College's privacy policies with your client (this will be provided to you in clinic)
- Complete Covid screening
- Complete medical/dental history
- Complete general release form
- Take vitals
- Complete your progress notes on the back of the medical history form
- Once completed- you will sign up to be evaluated. If any aspects outlined above are not completed, this will impact your grade. Please review your evaluation criteria and the clinic manual for conditions with medical alerts
- Once signed in- you will complete the screening on quadrants 2 & 3 ONLY. Once completed, sign up on your row sheet, to be evaluated.
- Complete screening and evaluated by instructor
- Receive a client chart; place stickers
- Start Hard Tissue
- Complete caries risk assessment

DENTAL HISTORY (Continued) When? How often? Identify any triggers?

14. Have you ever experienced any of the following jaw problems;
- | | | | |
|---|--|--------------------------|--------------------------|
| Popping/clicking in your jaw joints?..... | HOW LONG? HAS PT SEEN DENTIST DUE TO CONCERN | ☐ | ☐ |
| Pain in your jaw joints, around your ear or side of your face?..... | ^ | ☐ | ☐ |
| Difficulty in opening or closing?..... | ^ | ☐ | ☐ |
| Pain when teeth are clenched?..... | ^ | ☐ | ☐ |
| Pain or difficulty while chewing?..... | ^ | ☐ | ☐ |
15. Do you have any of the following habits:
- | | | | |
|--|--|--------------------------|--------------------------|
| Clenching or grinding your teeth while awake or asleep? | HOW OFTEN? ASK PT IF THEY HAVE/CONSIDERED NIGHTGUARD | ☐ | ☐ |
| Biting your cheeks or lips?..... | HOW OFTEN? | ☐ | ☐ |
| Mouth breathing while awake or asleep?..... | AWAKE OR ASLEEP OR BOTH? | ☐ | ☐ |
| Placing foreign objects in your mouth, nails, pipes, pins, fingernails?..... | Fingernails | ☐ | ☐ |
16. Do you have any emotional concerns about having dental treatment?
17. Are you satisfied with the appearance of your teeth?
- What would you like to see changed?
18. Have you ever had an upsetting experience in a dental office, or complications during or following dental treatment, or do you have any questions or concerns? **WHAT DENTAL TX WAS DONE? HOW LONG AGO? WHAT TRIGGERED PT EX. NEEDLES**

HEALTH HISTORY

1. Are you being treated for any medical condition presently or within the past two years?..... ☐ ☐
- If yes, please explain: IDENTIFY MEDICAL CONDITION AND WHEN?
2. Have you been hospitalized in the past two years? **WHEN?** ☐ ☐
3. When was your last visit to a physician? last complete examination? ☐ ☐
- DD / MM / YYYY
4. Have you recently or are you presently taking any PRESCRIPTION or NON-PRESCRIPTION drugs? **AND SUPPLEMENTS** ☐ ☐
- If yes, please list your daily dosage: 1. 2.
- *Do Not Include Multivitamins or Recreational Drugs*** 3. 4.
5. 5. 6.
5. Have you ever reacted adversely to any of the following? (Please circle) ANTIBIOTICS-Penicillin, Sulfonamide, other antibiotics – Aspirin, Barbiturates (sleeping pills), Codeine, Local Anesthetic (freezing), Nitrous Oxide, Any other medicine:
6. Have you ever been advised against taking any specific type of medication? Which?..... ☐ ☐
7. Do you have any of the following? (Please circle) Asthma, hay fever, Food allergies, Metal or Latex allergies, Skin rashes, Hives or any other allergic conditions **ALLERGY MARKED IN RED W/ MEDICAL ALERT** ☐ ☐
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath or chest constriction? ☐ ☐
9. Has any family member had or have diabetes?..... **MOTHER, FATHER, GRANDPARENTS, ETC** ☐ ☐
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily?..... ☐ ☐
11. Do your ankles, feet or hands swell?..... ☐ ☐
12. Has your weight, appetite or energy level changed dramatically recently?..... ☐ ☐
13. Do you experience shortness of breath or chest pain when walking or climbing stairs?..... ☐ ☐
14. Do you follow a special diet?..... ☐ ☐
15. Do you follow Canada's Food Guide ?..... ☐ ☐
16. Have you tested HIV positive?..... ☐ ☐
17. Do you have FREQUENT SEVERE headaches, earaches, and ear/throat infections?..... ☐ ☐
18. Have you ever had an injury or surgery to your face or jaws?..... **IF YES, IDENTIFY WHAT AND WHEN?** ☐ ☐
19. Do you wear eyeglasses or contact lenses?..... ☐ ☐
20. Do you smoke or use other forms of tobacco? Yes ☐ No ☐ Amount:
21. Do you use a vaping device? Yes ☐ No ☐ Amount:
22. Do you use cannabis for medicinal proposes? Yes ☐ No ☐ Condition:
23. Do you use cannabis for recreational proposes? Yes ☐ No ☐ Amount:
24. When was the last time you used cannabis? When:
25. Are you alcohol and/or drug dependent? Yes ☐ No ☐ Have you received treatment? Yes ☐ No ☐

Please ☒ which of the following do you presently have or have had:

- | | | | |
|--|---|--|--|
| ☐ A.I.D.S | ☐ Cortisone/steroid usage | ☐ Hepatitis C | ☐ Psychiatric treatment |
| ☐ Anemia | ☐ Diabetes Type 1 | ☐ Herpes | ☐ Rheumatic/scarlet fever |
| ☐ Angina pectoris | ☐ Diabetes Type 2 | ☐ High/Low blood pressure | ☐ Radiation treatment |
| ☐ Anorexia | ☐ Emphysema | ☐ Hodgkin's disease | ☐ Sickle cell disease |
| ☐ Artificial heart valve | ☐ Epilepsy or seizures | ☐ Hyper/Hypoglycemia | ☐ Sinus trouble |
| ☐ Artificial joints (hip, knee) | ☐ Fainting or dizzy spells | ☐ Intestinal problems | ☐ Stroke |
| ☐ Blood disorders | ☐ Glaucoma | ☐ Jaundice | ☐ Thyroid disease |
| ☐ Bronchitis | ☐ Glandular disorders | ☐ Lung disease | ☐ Tuberculosis |
| ☐ Bulimia | ☐ Heart disease or attack | ☐ Malignant Hyperthermia | ☐ Ulcers |
| ☐ Cancer | ☐ Heart pacemaker | ☐ Medical Implant | ☐ Venereal disease |
| ☐ Chemotherapy | ☐ Heart rhythm disorder | ☐ Mental/nervous disorder | ☐ Other _____ |
| ☐ Child Abuse/Spousal Abuse | ☐ Heart surgery | ☐ Mitral valve prolapse | ☐ Other _____ |
| ☐ Circulation problems | ☐ Hepatitis A | ☐ Organ transplant | ☐ NONE of the above |
| ☐ Congenital heart lesions | ☐ Hepatitis B | ☐ Osteoporosis | |

MEDICAL HISTORY (Continued)

26. **CHILDREN ONLY:** Has the child recently had any of the following (indicate approximate date) Yes No
- | | |
|--|---|
| ☐ Measles _____ | ☐ Strep Throat _____ |
| ☐ Mumps _____ | ☐ Tonsillitis _____ |
| ☐ Chicken Pox _____ | ☐ Other _____ |
27. **WOMEN ONLY:** Are you pregnant or suspect you may be?..... ☐ ☐
If yes, what is the expected delivery date? _____
Are you taking birth control pills? ☐ ☐
28. Do you currently have, or have you had in the past any diseases, condition or problem not listed in the health history?..... ☐ ☐
Please list _____
29. Is there anything else about your health we should be aware of? _____ ☐ ☐
30. Do you wish to speak to the Doctor privately about any problem or medical condition?..... ☐ ☐

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answer to any questions regarding my medical-dental history. If there is any further change in my health status, I will advise Oxford College of Arts, Business and Technology. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

Signature _____

☐ Client ☐ Parent ☐ Guardian ☐ Print Name ☐ Date

☐ Vital Signs B/P _____ mmHg Pulse _____ BPM Respiration _____ RPM

OFFICE USE ONLY BEYOND THIS POINT

- ☐ **Medical Status**
- () clear
- () medical conditions controlled and stable
- () compromised
- () M.D. clearance required
- () pre-medication required
- () dentist review required

INSTRUCTOR USE ONLY

- Medical Clearance**
pg 64 Clinic Manual
- Any cardiac conditions, including those that need PAC
 - PAC recommended for other medical conditions
 - Unstable medical or oral health condition where the condition may affect the safety of clients
 - Active chemotherapy or radiation therapy
 - Significant immunosuppression caused by disease, medications or other treatments
 - Any blood disorders
 - Active tuberculosis
 - Drug/alcohol dependency
 - Infective endocarditis
 - Drug combinations which may affect client safety

Reviewed by Registered Dental Hygienist: _____ **Do Not Forget to Get Instructor To Sign Before Screening**

OXFORD COLLEGE OF ARTS, BUSINESS AND TECHNOLOGY

Name: Hannah Peters D.O.B. 10/19/2000

Date of Screening: 06/20/2023 Screened by: Yumna Ali

☒ Number of teeth present 28 Last PSR Second PLAQUE INDEX First CALCULUS INDEX

☐ Dentures N/A

☒ Crowns & Bridges 14-24 P, 45-35 PFM

☒ PSR

☒ Plaque index

☒ Calculus (✓) supra 32% % of tooth surfaces 25-27 B/L, 36B/L, 37L loc: 1
(✓) sub 30% % of tooth surfaces All Interproximal Molars loc: 1

☒ Stain 50% % of tooth surfaces All Lingual Surfaces and 26 O locations

☒ Suspected Restorations required IN GREEN ONLY 16 MOB, 17 O, 47B, 47DL, 36MO, 25O, 27MOBL

☒ Suspected Extractions required IN GREEN ONLY 27 EXO

☒ Possible Radiographs IN GREEN ONLY 2BW, 4PA, 1 Panorex

☐ Translator required

☒ Classifications () DD1 (✓) DD2 () DD3 () DD4 Modifiers

DD LEVEL ONLY MARKED IN GREEN BY STUDENT, INSTRUCTOR WILL THEN CHECK AND EVALUATE DD LEVEL AND CHANGE IF NEEDED

☐ Not acceptable for treatment (specify reason) PT NEEDING MEDICAL CLEARANCE

☒ Acceptable for treatment **IF CLIENT REQUIRES A REFERRAL OR MEDICAL CLEARANCE, DOCUMENT IN SCREENING NOTES. EX. VITAL SIGNS: 159/90 mmHg. CLIENT GIVEN MEDICAL REFERRAL TO FAMILY PHYSICIAN AS PER CDHO GUIDELINES.**

SCREENING NOTES:

[Date] CONFIRMED TODAY'S APPOINTMENT WITH CLIENT ON 06/20/2023 IN PERSON. OBTAINED INFORMED VERBAL CONSENT FROM CLIENT TO PROCEED WITH OXFORD COLLEGE PRIVACY POLICY AND COVID SCREENING. PRIVACY POLICY READ AND UNDERSTOOD BY CLIENT. COVID-19 SCREENING READ AND SIGNED BY CLIENT. ALL ANSWERS REGARDING SYMPTOMS ANSWERED NEGATIVE. OBTAINED VERBAL AND INFORMED CONSET TO PROCEED WITH MEDICAL HISTORY. COMPLETED AND REVIEWED MEDICAL AND DENTAL HISTORY. CLIENT IS CURRENTLY NOT TAKING ANY MEDICATIONS AND HAS NO CONTRAINDICATIONS TO TREATMENT. (OR LIST ALL MEDICATIONS WITH DOSAGES AND ANY NOTED ALLERGIES.

INFORM OF ALL MEDICAL CONDITIONS CHECKED ON MEDICAL HISTORY. INFORM OF ALL DENTAL HISTORY AND TREATMENTS DONE. EXAMPLE: CLIENT HAD JAW SURGERY IN 2022 AND CURRENTLY EXPERIENCING POPPING/CLICKING... TAKEN VITALS: BP 159/90 mmHg, PULSE 78 BPM ON LEFT ARM, RESPIRATION 18 RPM. CLIENT HAS READ, SIGNED, AND UNDERSTOOD GENERAL RELEASE FORM. CLIENT RINSED WITH PRE-

PROCEDURAL MOUTH RINSE OF 7.5 mL LISTERINE ZERO FOR 30 SECONDS. OBTAINED VERBAL AND INFORMED CONSENT TO PROCEED WITH SCREENING. STERILIZATION INFORMATION: EXAM KIT STERILIZED ON (DATE), LOAD TYPE 5 CI PASSED AND DOCUMENTED Y. Ali

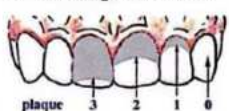
CLIENT SIGNED IN BY INSTRUCTOR AT S.GORDON
COMPLETED SCREENING. SEE SCREENING NOTES AND FINDINGS ABOVE. Y. Ali

SCREENING EVALUATED BY INSTRUCTOR AT S.GORDON

Screening is now completed and evaluated by instructor. From this point on NO NOTES are written in this area. All notes regarding HT, ST, Probing/Indices, DHD, etc. is written in the PROGRESS NOTES section

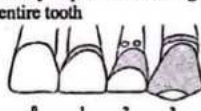
Plaque Index

- 0- No debris or stain
- 1- Soft debris covering 1/3
- 2- Soft debris covering 2/3 (up to middle)
- 3- Covering Entire Crown



Calculus Index

- 0- No calculus
- 1- Supra covering 1/3
- 2- Supra or Sub debris covering 2/3
- 3- Heavy Supra/Sub covering entire tooth



PSR Probing Recoding

- Code 0 (Absence)**
- Code 1 (Blood)**
- Code 2 (Calculus)**
 - Supra/Sub Calculus
 - Defective margins detected
- Code 3 (Disappear)**
 - Colour of probe partly visible in deepest sextant
- Code 4 (Everything)**
 - Probe completely disappears
 - Greater than 5.5mm
- Code ***
 - Furcation
 - Mobility
 - Recession (3.5mm↑)

Calculating % of Plaque/Calculus

Total # tooth parts with plaque x 100
6 x # of teeth present
= %
▪ Generalized= 80% (More)
▪ Localized= 30%