COVID-19 Patient Self Screening Form

Regardless of your vaccination status:

1. Have you experienced any of the following symptoms within the last 48 hours?
   (Note: please answer "yes" if you are experiencing any of the following symptoms, despite if you believe they are associated with the COVID-virus)
   - ☐Yes ☐ No Fever or chills
   - ☐Yes ☐ No Cough
   - ☐Yes ☐ No Shortness of breath and/or difficulty breathing
   - ☐Yes ☐ No Fatigue (unusual or unexplainable tiredness)
   - ☐Yes ☐ No Muscle or body aches
   - ☐Yes ☐ No Headache
   - ☐Yes ☐ No New loss and/ or taste of smell
   - ☐Yes ☐ No Sore throat
   - ☐Yes ☐ No Congestion and/or runny nose
   - ☐Yes ☐ No Nausea or vomiting
   - ☐Yes ☐ No Diarrhea
2. ☐Yes ☐ No Have you traveled outside United States in the last 14 days? Or traveled overnight *AND* used public transportation OR any overnight trip with persons outside of your household?
3. ☐Yes ☐ No Have you been in contact with anyone who has tested positive for COVID- 19?
4. ☐Yes ☐ No Have you tested positive with COVID-19 (or concerned that you may have COVID-19)?

I,_____, understand that my participation in the dental screening is voluntary. I am freely and voluntarily choosing to participate in the dental screening, being fully aware of the potential risk related to the transmission of the COVID-19 virus. I have had all of my questions addressed and am waiving any claim I might have, now or in the future, related to any injury or illness I could potentially sustain due to participation in the dental screening. I also waive any liabilities to any person or entity associated with the Dental Hygiene Program at West Georgia Technical College as it relates to the exposure risk of COVID-19. Furthermore, I am giving my express permission to be medically examined prior to commencing the dental screening.

Patient Name (Print): _____ Patient signature: _____

Student signature: _____ Date: _____

Student Initial	Patient Initial	Date

Student Initial	Patient Initial	Date

This form must be entirely completed and documented in the patient's records prior to patient escort and any rendered service within the clinic

Patient Dental & Medical Health History Information

Patient Information

Name _____ **Preferred Name:** _____ **Today's date:** _____

Birthdate:_____ **Age**:_____

Assigned sex at birth: ☐ Male ☐ Female **Gender Indentity**: ☐ Male ☐ Female ☐ Non-binary **Preferred Pronoun**:_____

Home Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Mobile:** _____ **Work:** _____

Email:_____

What is your preferred method of contact? ☐ Home Phone ☐ Text ☐ Email

In case of emergency, who should be notified? _____**Phone number:** _____

Relationship to patient: _____

Physician's name/Nearest Hospital: _____ **Physician telephone number:** _____

Dental office name:_____ **Dental telephone:**_____

When was your last dental visit? _____ **When was the time you had dental x-rays taken?** _____

Patient Physician Information

Are you currently under the care of a physcian? Yes ☐ or No ☐ **Reason?** _____**Results?** _____

What conditon(s) is being treated?

_____

Date of last physcian visit? _____ **Date of last physcial examination?** _____

Are you required to pre-medicate before any dental procedures? Yes ☐ or No ☐ If yes, why?

_____

Has there been any changes in your general health within in the last year. Yes ☐ or No ☐ If yes, what changed?

_____

_____

Have you had any serious accident, illness, or operation? Yes ☐ or No ☐ If yes, What & When?

_____

_____

Patient name: _____ Birthdate: _____

Do you have or have you ever had any of the following: Please check place a ✓ or X in each box.

Cardiovascular:
Angina pectoris…… Yes☐ No ☐
Myocardial Infarction…… Yes☐ No ☐
When? _____
Congenital heart defect…… Yes☐ No ☐
Rheumatic fever…… Yes☐ No ☐
Rheumatic heart disease…… Yes☐ No ☐
Heart Murmur…… Yes☐ No ☐
Hypertension…… Yes☐ No ☐
Stroke…… Yes☐ No ☐
Chest pain upon exertion…… Yes☐ No ☐
Pacemaker…… Yes☐ No ☐
Date placed? _____
High Cholesterol …… Yes☐ No ☐
Other heart conditions …… Yes☐ No ☐

Endocrine:
Pre-Diabetic…… Yes☐ No ☐
Diabetes If, yes: Current A1C _____ …… Yes☐ No ☐
Date: _____
Adrenal disorder …… Yes☐ No ☐
Thyroid disorder …… Yes☐ No ☐
Type? _____
Parathyroid disorder …… Yes☐ No ☐
Urination more than 6 times a day …… Yes☐ No ☐
Excessive thirst …… Yes☐ No ☐
Family history of diabetes …… Yes☐ No ☐
Other …… Yes☐ No ☐

GI/Liver:
Ulcers …… Yes☐ No ☐
Other hearth conditions _____
Hepatitis A☐ B☐ C☐ …… Yes☐ No ☐
Jaundice …… Yes☐ No ☐
Cirrhosis …… Yes☐ No ☐

Neurologic:
Alzheimer/Dementia …… Yes☐ No ☐
Paralysis …… Yes☐ No ☐
Epilepsy …… Yes☐ No ☐
Convulsion …… Yes☐ No ☐
Fainting spell or seizures …… Yes☐ No ☐
Anxiety…… Yes☐ No ☐
General ☐ or Dental ☐
Psychiatric treatment …… Yes☐ No ☐
Fibromyalgia …… Yes☐ No ☐
ADD/ADHD …… Yes☐ No☐
Other…… Yes☐ No ☐

Blood disorders:
Anemia …… Yes☐ No ☐
Bleeding disorder …… Yes☐ No ☐
Leukemia …… Yes☐ No ☐
Abnormal bleeding associated with previous extraction, surgery, or injury…… Yes☐ No ☐
Excessive bruising ……Yes☐ No ☐
Blood transfusion …… Yes☐ No ☐
Sickle cell disease …… Yes☐ No ☐
HIV/AIDS …… Yes☐ No ☐
Other …… Yes☐ No ☐

Respiratory:
Tuberculosis …… Yes☐ No ☐
Active ☐ non-active ☐
Emphysema …… Yes☐ No ☐
Asthma …… Yes☐ No ☐
Do you have an inhaler? …… Yes☐ No ☐
Persistent cough or cough up blood …… Yes☐ No ☐
Sinus trouble …… Yes ☐ No ☐
Do you use a CPAP machine …… Yes ☐ No ☐
Sleep Apnea …… Yes ☐ No ☐
Chronic obstructive pulmonary disease …… Yes ☐ No ☐
Shortness of breath …… Yes☐ No ☐
Shortness of breath while laying down …… Yes☐ No ☐
Require extra pillows to sleep …… Yes☐ No ☐
Other _____

Musculoskeletal
Prosthetics joint replacement …… Yes☐ No ☐
Osteoporosis ……Yes☐ No☐
Arthritis …… Yes☐ No ☐
Bone disorder …… Yes☐ No ☐
Muscular disorder …… Yes☐ No ☐
Inflammatory rheumatism ……Yes☐ No ☐

Genitourinary:
Herpes …… Yes☐ No ☐
Sexually transmitted infection …… Yes☐ No ☐
Type: _____
Kidney disease …… Yes☐ No ☐
Kidney dialysis …… Yes☐ No ☐
Stage _____
Other …… Yes ☐ No ☐

Other Conditions:
Are you pregnant?..... Yes☐ No ☐
Cancer …… Yes☐ No ☐
What trimester? 1st ☐ 2nd ☐ 3rd ☐
Chemotherapy…… Yes☐ No ☐
Are you nursing? …… Yes☐ No ☐
Radiation therapy …… Yes☐ No ☐
List any other conditions or diseases below
_____

Allergies
Local anesthetics …… Yes☐ No ☐
Penicillin or other antibiotics…… Yes☐ No ☐
Sulfa …… Yes☐ No ☐
Codeine or other narcotics …… Yes☐ No ☐
Aspirin or pain medicine ……Yes☐ No ☐
Latex ……Yes☐ No ☐
Hay Fever ……Yes☐ No ☐
Other…….... Yes☐ No ☐_____
Reaction:_____
_____
_____

Patient name: _____ Birthdate: _____

Are you taking any of the following medications

Antibiotics…….. Yes☐ No ☐
Anticoagulants (Blood thinner) …….. Yes☐ No ☐
High blood pressure medication……. Yes☐ No ☐
Birth Control……...Yes ☐ No ☐
Hormones…….. Yes ☐ No ☐

List all medications, supplements, and or vitamins you are currently taking.

_____

_____

_____

_____

Answer the following Questions related to your Dental History.

What is the reason for your visit today? _____
Does dental treatment make you nervous?..... Yes☐ No ☐
When was your last dental visit? _____
Did you have any xrays taken? ..... Yes☐ No ☐
What type of xrays did you have taken? ☐ BW ☐ Panoramic ☐ FMX ☐ single PA ☐ None
What date were these xrays taken? _____
Do you were dentures ☐ or partials ☐?.....Yes☐ No ☐
Have you ever had orthodontic (braces) treatment? When? _____.....Yes☐ No ☐
Are you currently experiencing any dental pain or discomfort? ……Yes☐ No☐
Are your teeth sensitive to: ☐ cold ☐ heat ☐ touch ☐ chewing ☐ sweets ……..Yes☐ No☐
Have you had an injury to your mouth, teeth, or head?.....Yes ☐ No☐
Does your gum ever bleed?.....Yes☐ No☐
What type of toothbrush do you use? Manual ☐ Battery powered ☐
Do you use a Soft ☐ Medium ☐ or Hard ☐ manual toothbrush?
How many times a week do you floss? _____
How many times a day do you use a toothbrush? _____
Do you snore?.....Yes☐ No☐
Are you conscious of bad breath or dry mouth?.....Yes☐ No☐
Have you been told you have gum disease?..... Yes☐ No☐
Have you ever had periodontal(gum) treatment? When? _____.....Yes☐ No☐
Do you experience difficulty with opening your mouth?.....Yes☐ No☐
Does your jaw ever hurt, pop, or click?.....Yes☐ No☐
Do you clench or grind your teeth?..... Yes☐ No☐
Do you wear a night guard?..... Yes☐ No☐
Have you been told you need a nightguard?..... Yes ☐ No☐
Do you get canker sores or fever blisters?..... Yes☐ No☐
Does food catch between your teeth?..... Yes☐ No☐
Do you smoke? If yes, check which product. Cigarettes ☐ Cigars ☐ Vape ☐ Marijuana ☐ Other _____Yes☐ No☐
How much do you smoke daily _____ How long have you been smoking? _____
Do you consume alcoholic beverages?..... Yes☐ No☐
How much do you drink a week? _____
Do you wear contacts? …… Yes☐ No☐
Are you on a special diet?..... Yes☐ No☐

To the best of my knowledge, the above medical and dental history is correct. I hereby consent to such examinations, radiographs (x-rays), diagnostic procedures, and tests that may be prescribed. I assume any risk associated with any treatment performed. Students and facilities may not be used for personal gain or profit. Records become property of West Georgia Technical College – Douglasville.
Rev. 1-2026
Guardian signature required if patient under 18 years of age

Patient/Parent/Guardian Signature: _____ Date: _____
Student Signature: _____ Date: _____

Consent/Authorization for Treatment

- I understand this program is a training program and that my treatment will be rendered by a student clinician under supervision of qualified licensed faculty.
- I understand that because my treatment is rendered by a student, the treatment may involve several hours in the clinic and may also involve several appointments to complete my treatment.
- Permission is hereby given for treatment documented in my treatment plan. Treatment by my student clinician and faculty member may include but may not be limited to x-rays, impressions of my mouth for study models, photographs, preventive chemotherapeutic agents, sealants, prescriptions and/or non-prescription medication, etc.
- I understand that these records may be used for educational purposes.
- I understand that this program renders preventive dental hygiene services, and does not render any restorative (restorations, crowns, bridges, dentures), surgical (extractions, biopsies), nor provisional (temporary restorations, pain relief, infection treatment, root canals, orthodontic) treatment.
- I understand that during my treatment defective filling may be dislodged or crowns may become loose. I understand that this can be, but is a rare, complication of a dental hygiene care and I assume full responsibility for repair, cementation, or restoration replacement by my family dental practitioner.
- I understand that I may be referred to licensed practitioners for further treatment and I assume full responsibility to seek and have further treatment rendered.
- I understand that because this is an educational faculty, I will not be able to have a dental cleaning at the recommended re-care interval and should visit my dental office routinely.

In the case of a minor or mentally handicapped patient, the consent(s) below is/are being given on his behalf.

Patient/Parent/Guardian signature: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY RIGHTS

I acknowledge that I have read and received the Program's notice of Privacy Policies and Individual right.

Patient/Parent/Guardian signature: _____ Date: _____

Consent to obtain records or information (May be required for treatment**)**

☐ I hereby authorize West Georgia Technical College, Department of Dental Hygiene to obtain permission medical information and/or records from my physician, physical assistant, nurse practitioner or other medical facility during my treatment.

☐ I understand that any obtained above information will be kept confidential in accordance with the Notice of Privacy Policies I have read and signed.

Consent to release records or information

☐ I hereby authorize West Georgia Technical College, Department of Dental Hygiene to release my protected health information and those of my children, to my spouse, family member or significant other or to any person(s) listed below:

1. _____
2. _____

☐ I do not authorize any information to be released to anyone other myself.

Consent for communication

☐ I hereby authorize messages to be left on an email/voicemail/via text. Please provide the number(s) that staff and student may utilize to leave a message for. _____

Consent to release radiographs

☐ I authorize release of radiographs to the following dentist. _____

I understand that I will be provided copies of current radiographs if there is no current charge on my account.

Patient/Parent/Guardian signature: _____ Date: _____

Patient's Rights and Responsibilities of
West Georgia Technical College Dental Hygiene Program

Welcome! Our goal is to assist you in eliminating and preventing oral disease so that you may keep your natural teeth healthy. It is our desire to provide considerate, respectful, and confidential dental hygiene care.

Since our goal is comprehensive dental hygiene care and the student is responsible for providing complete services, your participation in his/her learning experience is essential. It is important for you to understand that this is an educational setting that the student's grade depends on your full cooperation. If for some reason you will not be able to keep an appointment, **please call the clinic 48 hours in advance** so that the student can make plans to see another patient during that time.

Your first visit will involve a thorough examination, which will include the following procedures:

1. A medical history to determine general health and any specific conditions altering the process of your treatment.
2. A comprehensive oral examination to detect the possible presence of abnormal tissues.
3. A preliminary report of your oral health status, recommended treatment, treatment alternatives, option to refuse treatment, risk of no treatment, and expected outcomes.
4. A dental hygiene treatment plan to inform you of treatment process and number of appointments necessary.
5. X-rays if indicated.
6. Oral health instructions, which will continue at all subsequent visits.
7. Referral to a dentist or physician for evaluation of noted conditions.
8. Because this is a learning institution, radiographs and chart information may be used for educational purposes.

Most patients require **more than one visit** for the completion of services. We strive to keep the number of appointments required to a minimum, as we realize that your time is valuable. Please be prompt so that we can serve you and others without necessary delay. Occasionally unforeseen situations arise and will cause us to run behind schedule. However, every effort will be made to keep you from waiting any longer that is absolutely necessary.

We thank you for making your appointment with us and look forward to serving you!

Parent/Legal Guardian's signature: _____Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL AND DENTAL INFORMATION ABOUT YOU MAY BE USED, AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THESE POLICIES CAREFULLY.

1. This program is required by law to maintain the privacy of protected health information and to provide Patients/guardians with notice of its legal duties and Privacy practices with respect to protect health information.
2. This program is a student-oriented training program. The program does not submit information for insurance payment purposes. Payment is fee-for service only.
3. Since this program is a training program to educate future Dental Hygienist, your information may be used as educational material to benefit other students who have not directly participated in your direct care. If your protected health information is used, all reasonable efforts will be made to conceal your identity, including photographs. If your protected health information may reveal your identity, all reasonable efforts will be made to obtain your written consent to use such information.
4. The program may at times find it necessary to release all or portions of your protected health information to other healthcare workers without the Patient's/Guardian's written authorization. Examples of this release of information would include referrals to dentists for work to be performed, submissions of copies of x-rays made in our facility, physicians requests, or when required by law, or enforcement officials. Other uses and disclosures will be made only with the patient's written authorization, and the patient may revoke authorization at any time.
5. The program may disclose protected health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or other crime in order to avert a serious threat to your health or safety or the health or safety of others.
6. The program may contact the Patient/Guardian or the patient's family members to provide appointment reminders, treatment(s) to be performed, treatment alternatives or other health related benefits and services that may be of interest to the patient and premedication reminders. In the event of an emergency, the program may disclose pertinent information to responding healthcare personnel. The program will use its professional judgment in disclosing only health information that is directly relevant to your care.
7. The program will use its professional judgment and its experience with common practice to make reasonable inferences of your best interest in allowing a person to pick-up prescriptions, medical/dental supplies, x-rays or other similar forms of health information.
8. The program reserves the right to change the terms of this notice. Any changes will be provided to the Patient /Guardian by copies of the revised Notice

THE PATIENT/GUARDIAN HAS THE FOLLOWING RIGHTS REGUARDING PROTECTED HEALTH INFORMATION:

1. The right to request restrictions on certain uses and disclosers of protected heath information.
2. The right to receive confidential communications of protected health information, as applicable.
3. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
4. The right to amend protected health information. The program reserves the right to refuse to amend protected health information if it determines such amendment is false or fraudulent.
5. The right to receive an accounting of disclosers of protected health information.
6. The right to obtain a paper copy of this notice upon request.
7. Patients may complain to the Program's HIPAA Privacy Officer or the Secretary of Health, and human Services without fear of retaliation by the program if they believe their privacy rights have been violated.

   Direct a written copy of the facts and allegations of your complaint to the HIPAA PRIVACY OFFICIER at the address below:

HIPAA Privacy Officer♦Dept. of Dental Hygiene♦West Georgia Technical

Patient's Rights

1. Considerate, respectful and confidential treatment with the right to approve or refuse the release of their medical/dental records to any individual outside of the dental hygiene clinic facility.
2. Access to complete and current information about his/her condition and the rights to participate in the planning of their dental hygiene care.
3. Advanced notice of the cost of their treatment
4. Advanced knowledge of the services that can be rendered in the Dental Hygiene Clinic
5. Compliance with the infection control guidelines recommended by the Centers for Disease Control and Occupational Safety and Health Administration
6. An explanation of recommended treatment, alternative treatment, the option to refuse treatment and the risk of no treatment
7. Treatment that meets the standard of preventative care in the profession
8. Referral information to take to a dentist for comprehensive dental care.

Dental Hygiene Clinic Information

1. Patients are seen by appointment only.
2. Patients may call for an appointment at **(770) 947-7210**
3. All clinic procedures are provided by dental hygiene students under the direct supervision of licensed dental hygiene faculty of the Department of Dental Hygiene. The patient must see a dentist for anything other than dental hygiene care.
4. Payment for treatment is made before treatment is rendered. Payment method accepted: cash, credit/debit and apple pay.
5. The dental hygiene clinic **does not** accept insurance.
6. Patients need to be present and on time for **all** appointments, as well as stay the full length of the appointment. Depending on patient's oral status, multiple appointments may be required for completion.
7. Patient must provide 48-hour cancellation notice, after 3 broken appointments, the patient will not be able to schedule another appointment until six months from the last broken appointment day.
8. No unaccompanied children are allowed in the waiting area; only children with an appointment are allowed in the treatment area

BLOODBORNE PATHOGEN/HAZARD COMMUNICATION POLICY

I have been notified of the Bloodborne Pathogen/Hazard Communication Policy at West Georgia Technical College Dental Hygiene Department. I understand that I have the option to receive a copy of the policy upon request.