

Patient's Name \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_

**Please review this clinic policy. Your initials and signature assures us your understanding and acceptance to adhere to our Clinic Policies.**

## UAA Dental Clinic Policy

### Acceptability for Treatment

- a. Most services performed in the UAA Dental Clinic are performed by *students* under the guidance and supervision of licensed dentist and faculty members. Performing these services provides the students with the clinical experience mandatory for preparation as a dental professional. Because the services are performed by *students*, the work may require more time than if it were performed by experienced dental professionals. The purpose of our services is educational; in the hygiene clinic, we do not provide a comprehensive dental examination. Every patient will be expected to complete treatment that has been previously committed to the student and clinic. Your oral condition lends itself to student instruction and learning; their grades depend upon the completion of your care.
- b. Absence of any medical or dental condition which precludes treatment. A written statement may be requested from your physician before treatment will be rendered. Treatment may not be rendered to patients with certain medical conditions without the return of a medical consent form.
- c. Appropriate patient behavior in our clinic is defined as:
  - Being on time for every appointment
  - Fulfilling your commitment to the student requirements for grading
  - Proper behavior is required. Any offensive or abusive language or action will not be tolerated. Improper behavior is cause for treatment termination and dismissal.
- d. Your oral condition lends itself to student instruction and learning.

### Appointments

- a. You are urged to keep **all** scheduled appointments. If you are unable to keep your scheduled appointment, notify the UAA Dental Clinic at 786-6960, **at least 24 hours in advance** to allow sufficient time to schedule another patient. A **\$25 fee** will be charged for appointments that are broken or cancelled within 24 hours before the scheduled appointment.
- b. If you are more than 15 minutes late for your appointment without prior notification, another person may be scheduled for that appointment time.
- c. If you are late twice or miss more than one appointment without prior notification to the UAA Dental Clinic, we will interpret that as a dismissal of our treatment and we may discontinue your treatment and inactivate your file.
- d. Because our clinic is a learning institute, it is important to our instruction that hygiene patients have a sufficient amount of calculus for students to fulfill their grading requirements. Due to those guidelines, it is important to understand that after four (4) semesters we may no longer be able to appoint you and may refer you to private practice to meet your dental needs.

### Children (Hygiene Department only)

- e. Children **MUST** be supervised at **all times** by a parent or guardian. If a parent is being seen, we recommend parents to make arrangements for the supervision of their children. Unsupervised and/or unruly children will not be permitted in the dental program area. A child is considered anyone under 18 years of age. Before treatment can be provided, a parent or legal guardian must sign a patient treatment plan authorizing treatment for their child(ren).
- f. A parent or guardian must remain in the facility while their child is being treated. Legally, we cannot treat minors without: a) a parent's/guardian/s signature on the treatment plan; b) a parent present on the premises.

### Radiographs

- a. Radiographs (x-rays) are taken by the student only by *prescription* of an Alaska licensed dentist and are the property of the UAA Dental Clinic. Duplicates are given to the patient, however, duplicates may **NOT** be hand carried by staff or students. If you wish duplicate radiographs forwarded to your dentist, please call the Dental Programs at least two (2) weeks in advance. Duplication of x-rays is **NOT** available from May 1 through September 15. A Consent to Release will be required by UAA for each specific release of records.

- b. Radiographs are taken at the clinic dentist's discretion. Radiographs are required for ALL new patients. A new patient is considered someone that is not in our electronic dental records and/or does not have a previous paper chart.
- c. If a radiograph is needed to diagnose an area of concern or for the purpose of student teaching, the patient will allow the final determination to be decided by the licensed dentist. Failure to allow radiographs will result in termination of services. Radiographs are necessary to diagnose any and all dental needs.

**Fees**

- a. Fees will be determined upon completion of the oral evaluation during the initial assessment appointment. Payment is due following the initial appointment. We do not file insurance claims. We will provide you with a receipt for your dental claim after payment is rendered.

**Request for Treatment and Release from Liability  
UAA Dental Clinic Programs  
Please Read Carefully**

The purpose of our services is educational; services require long appointments to assist students with meeting learning requirements.

Students are required to obtain a complete medical and dental history for each patient prior to initiating services. Such information is essential for the performance of adequate dental services and is considered confidential. We utilize open operatories for educational purposes. If you prefer more privacy to discuss your concerns, please inform the student or staff.

**Authorization and Release**

- A. I authorize the performance of the following services on the above named person: oral prophylaxis, fluoride applications, dental x-rays, restoration placement and finishing, crowns and other dental services including, but not limited to local anesthesia as deemed advisable by the supervising dentist.
- B. I consent to the photographing or televising of the procedures or operations for dental, scientific or educational purposes, providing my identity is not revealed.
- C. I consent to visitor observation of services performed. I understand that the services will be performed by a dental *student* under the guidance of a professional dental instructor and the direct supervision of a licensed dentist.
- D. I request treatment afforded through the Dental Clinic Program of the University of Alaska Anchorage, for myself and/or on behalf of my minor child or children. In consideration of receiving treatment, on behalf of myself, my heirs, executors, administrators, or assigns and on behalf of my minor child or children and assigns, I agree to indemnify and save harmless the University of Alaska, its Board of Regents, officers, agents, employees and students from and against all claims, demands, judgments, costs and expenses (including reasonable attorney's fees) which may arise by reason of injury to any person or damage to any property attributable to the negligent acts or omissions of the University of Alaska, its officers, agents, employees or students in connection with such treatment. However, nothing contained herein shall be construed so as to relieve the University of Alaska, its Board of Regents, officers, agents, employees or students from liability as a result of its or their own gross negligence.
- E. I understand that the services I receive through the University of Alaska Anchorage Dental Clinic Program are not designed to be a substitute for periodic visits with a licensed professional dentist. Patients are to advised to continue to seek regular dental care from a licensed dentist and registered hygienist, separate from UAA Dental Clinic.
- F. I understand that, with my permission, I may be given a local anesthetic injection and that in rare instances patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I hereby acknowledge that I have read this Request for Treatment and Release from Liability Agreement and that this Agreement is executed freely and voluntarily by me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

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Patient

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If Minor, signature of Parent or Legal Guardian