

INSTRUCTIONS:

Please fill out this document. Bring this form with you to your preliminary consultation appointment. If you are unable to print this document we have forms at the clinic.

A preliminary consultation is the **only** free appointment that you will have. This appointment is for students to examine your mouth for certain characteristics they are looking for, to fulfill their clinical requirements. If you qualify, you will be placed in a pool of patients that the students will select from to meet their clinical education needs. If a student takes your case, you will be contacted by that student for the first appointment.

The first appointment will be three hours in length. You will be responsible for payment of services at the end of each appointment. It will take multiple appointments to complete your treatment and payments will be spread out over these appointments. If you have **insurance** this information will be required **before the first appointment**. An insurance form is available for download at: <https://www.lwtech.edu/campus-life/dental-clinic/>

Patient Screening Form
 Lake Washington Institute of
 Technology Dental Hygiene Program

AAP/Class:	PSR						
____/____/____ I.I. ____	<table border="1"> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>						
<i>Student assignment/date:</i>							

H52

Today's Date: _____

Appt. Date: _____

DENTAL Insurance (for future appointment upon qualifying): YES or NO If yes, fill out the following:

Provider One or Apple Benefit Plan _____ **WA**

Non-Apple dental insurance: Name of Ins. _____ Phone Insurance _____

Subscriber name and birthdate _____ Employer _____

Subscribers SS# or ID# _____ Group # _____

Patient Information

Name:	First:	Last :		
Address:	Street:	Apt. #		
Phone:	City:	State:	Zip:	
Date of Birth:	Home :	Cell:	Work:	
	Mo:	Day:	Year:	M ____ F ____
				Email:

Dental History

What is your reason for contacting the LWTech dental clinic?	
Date/year of last dental visit:	Date/year of last dental cleaning:
Name of previous dentist:	Phone number of dentist:

Patient Medical History

Have you ever had or experienced any of the following conditions? Circle yes or no to all questions:

1. Heart Condition	Yes No	2. Diabetes	Yes No
3. Heart Surgery	Yes No	4. Tuberculosis	Yes No
5. Valve Replacement	Yes No	6. Kidney/Renal Disease	Yes No
7. Stroke	Yes No	8. Hepatitis/Jaundice	Yes No
9. High Blood Pressure	Yes No	10. Latex Allergy	Yes No
11. Bleeding Disorder	Yes No	12. Epilepsy/Seizures	Yes No
13. Asthma/Respiratory Problems	Yes No	14. Joint Replacement	Yes No
15. Are you taking any medications?	Yes No	16. Women only: Are you pregnant?	Yes No
17. List all medications: _____			
Allergies to medications: _____			
List any other conditions we should know about: _____			

B.P.

Patient Signature _____ Date: _____

While we do our best to accommodate everyone who seeks care at the LWTech dental clinic, the students have specific learning requirements that must be completed in order to graduate, and not everyone's treatment needs meet this criteria. You may have to wait several months to be appointed, or we may not be able to complete all aspects of your care. Short notice availability will increase the likelihood of gaining acceptance as a patient if you do not initially qualify for a cleaning. Please read and initial the statement below:

"I understand that this is a learning institution, and only those persons who meet the specific requirement needs of the students will be selected for treatment at the LWTech Dental Clinic." Pt. Initials _____

PATIENT CONSENT & DISCLAIMER FORM

This is a periodontal screening appointment for evaluation purposes only and does not guarantee diagnostic treatment (doctor’s exam or radiographs) nor dental hygiene treatment (cleaning) between myself and any student of the Lake Washington Institute of Technology Dental Hygiene Program. The Lake Washington Institute of Technology, dental hygiene students, faculty, and staff assume no liability with regard to my dental health and cannot guarantee to provide dental services at this time unless otherwise specified. I understand treatment will be performed and completed by multiple dental hygiene students under the direct supervision of licensed professionals and only treatment selected for teaching purposes will be carried out. I understand I may or may not meet the needs as a patient for teaching purposes and I may not be able to have my dental needs treated in this clinic.

If I am called to be scheduled in the dental hygiene clinic, I will be responsible for payment of fees on the date when treatment is rendered. I understand there are **multiple** appointments that are **2.5 – 3 hours** each. I further understand I may be put into a pool of patients for students to draw from and I may or may not be called to proceed with dental hygiene care. If I am **not** called and/or if immediate treatment is needed, I should consult my regular dental care provider and if I do not have a regular dental provider, then a list of low cost dental care providers is available to me.

I understand that Lake Washington Institute of Technology dental clinic does offer dental exams along with full mouth radiographs and can meet most of my **restorative** needs in the Restorative Clinic. I have read and received a copy of the Dental Clinic’s Notices of Health Information Practices which provides information about how my health information will be used and disclosed.

Can we leave a detailed message on your phone? Yes No

Patient or Guardian Signature: _____

Print Name: _____

Date: _____

Lake Washington Institute of Technology Dental Clinic

Patient Information Demographics

The purpose of this form is to collect information not found on the default check in forms. We collect the information below in order to provide you the best care.

Gender Identity

Female Male Transgender Non-Binary/Gender queer Other Prefer not to disclose

Preferred Pronoun

She, Her, Hers He, Him, His They, Them, Theirs Prefer not to disclose

Race or background

American Indian/Alaska Native Asian Black/African American
Native Hawaiian Other Pacific Islander White
More than one race Decline to Identify

Hispanic or Latino

Yes, Hispanic or Latino Not Hispanic nor Latino Decline to disclose

Employment Status

Full Time Child Self Employed
Part Time Not Employed Retired
Seasonal Active Military Student

Insurance

Yes No

Yearly Income _____ Monthly if easier to calculate _____

Number in Household _____

I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct and that my foregoing attestation is true and correct

Sign _____

Date _____

PRINT NAME _____

City _____