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

Today's Date:_____

AAP/Class: **PSR**

_____/____/_____ **I.I.**_____

Student assignment/date:

H52

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. #**	
	City:	**State:**	**Zip:**
Phone:	**Home :**	**Cell:**	**Work:**
Date of Birth:	**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.

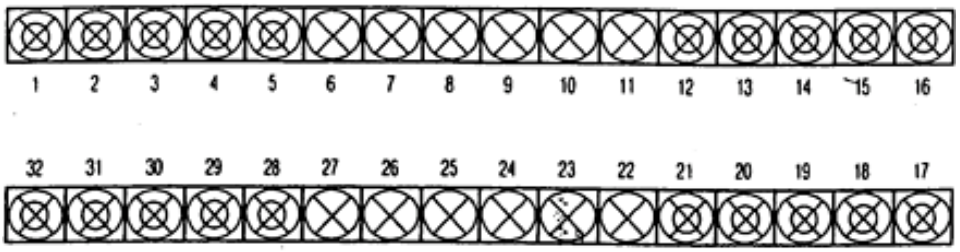
Patient Signature _____ **Date:** _____

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 _____

Appointment Notes *(student use)* **Include patient availability (best days, times), and appointment considerations:**
DHS: **I.I**

PT (circle one): INTERESTED NOT INTERESTED



Medical History Review Section (notes from first page of the medical history review)

Number:	Notes:	Number:	Notes:

DATE	NOTES related to phone calls (i.e. who called and the result of the call)	DHS

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: _____