



Dental Hygiene Program

UNIVERSITY of ALASKA ANCHORAGE

UAA Dental Clinic Policy

Patient's Name: _____

Date of Birth: _____

Please review these clinic policies. Initial each section and sign below, ensuring us you understand, accept, and will adhere to our UAA Clinic Policies.

Acceptability for Treatment

Most services in the UAA Dental Clinic are performed by students under the direct supervision of licensed dentists and Registered Dental Hygienists. These services provide students with the essential clinical experience required for their preparation as dental professionals. Because treatment is provided by students, procedures may take longer than if performed by experienced dental practitioners. The primary purpose of our services is educational. In the hygiene clinic, we do not provide a comprehensive dental examination. All patients are expected to complete the treatment that has been assigned and committed to both the student and the clinic. Your oral condition supports student learning, and students' grades are dependent upon the completion of your care.

A. Medical and Dental Conditions

Treatment may only be rendered in the absence of any medical or dental condition that would preclude safe care. A written statement from your physician may be required before treatment can proceed. Patients with certain medical conditions may not receive treatment without a returned and approved medical consent form.

B. Appropriate Patient Behavior

Patients are expected to demonstrate appropriate behavior in the clinic, which includes:

- Arriving on time for all scheduled appointments
- Fulfilling commitments necessary for students to meet grading and clinical requirements
- Always maintaining respectful conduct. Offensive or abusive language or behavior will not be tolerated. Improper behavior may result in termination of treatment and dismissal from the clinic.

C. Educational Purpose of Care

Your oral condition is suitable for student instruction and contributes to their clinical learning experience.

Appointments

A. Patients are expected to keep all scheduled appointments. If you are unable to attend, please notify the UAA Dental Clinic at 786-6960 at least 24 hours in advance so another patient may

be scheduled. A \$25 fee will be assessed for appointments that are broken or cancelled within 24 hours of the scheduled time.

- B. Patients arriving more than **15 minutes late** without prior notification may forfeit their appointment, and another patient may be scheduled in their place.
- D. Patients who arrive late on two occasions, or who miss more than one appointment without notifying the UAA Dental Clinic, will be considered to have dismissed treatment. In such cases, care may be discontinued and the patient file inactivated.

Children (3- 18 yrs.)

- A. Children must be always supervised by a parent or legal guardian. If a parent is receiving treatment, arrangements should be made for the supervision of children. Unsupervised or unruly children are not permitted in the dental program area. For purposes of this policy, a child is considered anyone under **18 years of age**. Before treatment can be provided, a parent or legal guardian must sign the patient treatment plan authorizing care for their child(ren).
- B. A parent or legal guardian must remain in the facility while their child is being treated. Legally, we cannot treat minors without both:
 - 1. A parent's/guardian's signature on the treatment plan,
and
 - 2. A parent or guardian present on the premises during the appointment.

Radiographs

- A. Radiographs are taken by students only with a prescription from an Alaska-licensed dentist and remain the property of the UAA Dental Clinic. Copies may be provided to the patient or forwarded to a dental professional's office upon request.
- B. If you would like your radiographs forwarded to your dentist, please contact the Dental Programs at least two (2) weeks in advance. Please note that copies of radiographs are not available between May 15th and September 1st due the summer break.
- C. *A Release of Information* (ROI) form is required by UAA for each type of record requested.
- D. Radiographs are taken at the discretion of the clinic dentist and are required for all new patients. A new patient is defined as an individual who is not recorded in the electronic dental records system and/or does not have a previous paper chart on file.
- E. Failure to allow radiographs will result in termination of treatment. Radiographs are necessary to diagnose all dental needs.

Fees

- A. Fees are determined following the oral evaluation conducted during the initial assessment appointment. Payment is required at the start of consented treatment. The UAA Dental Clinic does not file insurance claims; however, a receipt will be provided after payment is received so you may submit it to your dental insurance provider.

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

Educational Purpose of Services

The primary purpose of our services is educational; therefore, appointments may be longer to meet student learning requirements. Prior to beginning care, students are required to obtain a complete medical and dental history from each patient. This information is essential to ensure safe and adequate dental services and will be kept strictly confidential.

For instructional purposes, the clinic utilizes open operatories. If you prefer additional privacy to discuss personal concerns, please inform the student or a faculty member.

Consent for Treatment and Release from Liability

A. Authorization for Services

I authorize the performance of the following services on the above-named person: oral prophylaxis, fluoride applications, dental radiographs, restorative placement and finishing, crowns, and other dental services, including but not limited to local anesthesia, as deemed advisable by the supervising dentist.

B. Consent for Photography/Televising

I consent to the photographing or televising of procedures or operations for dental, scientific, or educational purposes, provided that my identity is not revealed.

C. Consent for Observation

I consent to educator and student observation of treatment performed. I understand that treatments will be provided by a dental hygiene student under the guidance of a professional dental instructor and the direct supervision of a licensed dentist.

D. Request for Treatment and Release

I hereby request treatment through the Dental Clinic Program of the University of Alaska Anchorage for myself and/or on behalf of my minor child(ren). In consideration of receiving such treatment, I, on behalf of myself, my heirs, executors, administrators, and assigns, as well as on behalf of my minor child(ren) and their assigns, agree to indemnify and hold harmless the University of Alaska, its Board of Regents, officers, agents, employees, and students from any and all claims, demands, judgments, costs, and expenses (including reasonable attorney's fees) that may arise from 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 said treatment. This provision shall not be construed to relieve the University of Alaska, its Board of Regents, officers, agents, employees, or students from liability arising from their own gross negligence.

E. Acknowledgment of Limited Scope of Services

I understand that the services provided through the University of Alaska Anchorage Dental Clinic Program are educational in nature and are not intended to replace routine care by a licensed dentist. I acknowledge the importance of continuing regular dental visits with a licensed dentist and registered dental hygienist outside of the UAA Dental Clinic.

F. Local Anesthetic Disclosure

I understand that, with my consent, I may receive a local anesthetic injection. I acknowledge that, although rare, patients may experience allergic reactions, adverse medication responses, or temporary or permanent injury to nerves or blood vessels. I also understand that the injection site may be uncomfortable after treatment and that my jaw may feel stiff or sore from keeping my mouth open during procedures.

Patient Signature: _____ **Date:** _____

Signature of Parent or Legal Guardian (for Minor Patient):

Date: _____