

FULLERTON DENTAL ASSISTANT SCHOOL

CORONAL POLISHING EVALUATION SHEET

School _____

Patient Name: _____

Student Name _____

PMH (circle one) _____ positive / negative _____

Date _____

The Coronal Polishing clinical examination must be passed by a score of 75% or higher. This will be filed in your permanent record per state regulation.

Evaluated items that are preceded with an asterisk (*) are considered critical steps in the coronal polishing procedure. A score of 19 must be obtained in the critical steps to pass.

Items Evaluated	Grade	Reason (if applicable)
*1. Reviewed Patient Health History		
*2. Operator utilized the proper PPE		
3. Prepare Patient		
*4. Explain procedure to patient		
5. Select armamentarium to be used		
6. Utilization of armamentarium in a organized sequence		
7. Disclosed Oral cavity = Identify plaque, stain		
8. Correct positioning of the operator and patient		
9. Establish handpiece control, modified pen grasp of retention		
*10. Utilize a stable intraoral fulcrum for all areas of the mouth		
11. Adapt the proper cup to the tooth surface without damaging the gingival tissue.		
a. Into the Proximal Areas		
b. Into the Gingival Areas		
12. Select and dispense the proper amount of polishing agent		
13. Utilize a controlled, light lifting-wiping stroke while avoiding excessive heat		
14. Utilize the moistened bristle cup brush to cleanse the occlusal surface		
*15. Use floss for cleansing all proximal surfaces		
16. Final disclosure of mouth- check effectiveness of the polishing procedure		
*17. Demonstrate proper disinfection and sterilization technique		
Total Points Earned		FINAL PERCENTAGE
Total Points Possible	180	

TOTAL POINTS EARNED ÷ TOTAL POINTS POSSIBLE = FINAL PERCENTAGE

POINT	10 points = EXCELLENCE	All skills criteria were performed; performance was excellent
BREAKDOWN	8 points = GOOD	Student performed all skill criteria well but could improve
	7 points = SATISFACTORY	Student performed skill criteria adequately with room of improvement
	0 points = FAILURE	Student failed to perform enough of the skill to evaluate

CALCULUS FREE (circle one) yes / no
(Dentist to indicate-patient must be calculus free)

Supervising Instructor Signature

Supervising Dentist Signature

Fullerton Dental Assistant School
Coronal Polishing
Patient Consent Form

I, _____, give authorization to have my teeth coronal polished by _____, a dental assisting student of Fullerton Dental Assistant School, to satisfy his/her coronal polish certification requirements.

The coronal polishing procedure will consist of the removal of plaque and extrinsic stains by a rotating rubber cup, brush and polishing paste and will be done under the direct supervision of a licensed dentist (the “polishing procedure”). I understand that a dental assistant does not diagnose illness, disease, or any other physical or mental disorder. As such, the dental assistant prescribes neither medical treatment nor pharmaceuticals. It has been made very clear to me this polishing procedure is not a complete prophylactic (teeth cleaning) procedure. This polishing procedure is not being administered to treat or diagnose any current or pre-existing ailment or injury. Because certain dental procedures should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions.

I also understand that the dental assisting student identified above is a student in training and is not a licensed or registered dental assistant, dentist, doctor or nurse. I recognize that Fullerton Dental Assistant School supports this polishing procedure in order to provide dental assisting students with practical hands-on experience and that I am receiving this polishing procedure at no charge in light of these facts. No oral statements contrary to this disclosure have been stated to me.

In consideration of the dental assisting student identified above administering the polishing procedure, I, for myself, my heirs, executors, administrators and assigns:

1. Release such student and Fullerton Dental Assistant School its affiliates, servants, agents or employees from any claims, demands, damages, actions or causes of action arising out of or in consequence of any loss, injury or damage to my person or property incurred in connection with the polishing procedure, notwithstanding that any such loss, injury or damage may have arisen by reason of the negligence of Company, its affiliates, students, servants, agents or employees;
2. Fully understand the risks and dangers of the polishing procedure and accept these risks and dangers entirely at my own risk;
3. Fully understand that my participation in the polishing procedure program is entirely voluntary;

4. Agree that Company shall not be liable to me for: (a) any loss (including loss by theft) or damage to my property, or the property of others, which property shall be my sole risk; or (b) any injury to, or death of, any persons including me, in each case resulting from or in connection with the polishing procedure or the Company's, or any of its employees', students' or agents', acts or omissions;
5. Agree to indemnify Company, its affiliates, servants, agents or employees from any claims or demands which might be made against Company arising out of or in consequence of the polishing procedure; and
6. Represent that I am the full age of eighteen (18) years or older, or the parent or legal guardian of the participant named above.

BY SIGNING THIS AGREEMENT, I AGREE TO ACCEPT ALL RISK AND RESPONSIBILITY RELATING TO THE POLISHING PROCEDURE.

Signature

Print Name

Date

UPDATED MEDICAL HEALTH HISTORY FORM

Name: _____ Date of Birth _____

Your Physician's Name: _____

Your Physician's Address: _____

Briefly describe your general health. _____

Directions: Circle YES or NO to the following:

1. Have you ever had any of the following:

- | | | | |
|-----------------------|--------|-------------------------|--------|
| Measles | YES NO | Jaundice | YES NO |
| Epilepsy | YES NO | Venereal disease | YES NO |
| Diabetes | YES NO | Rheumatic fever | YES NO |
| Tuberculosis | YES NO | Chicken Pox | YES NO |
| Heart Attack | YES NO | Hepatitis | YES NO |
| Mumps | YES NO | Stroke | YES NO |
| Ulcers | YES NO | Asthma | YES NO |
| Thyroid Disease | YES NO | Anemia | YES NO |
| Liver Disease | YES NO | Emotional disease | YES NO |

2. Have you been examined by a physician in the last year? YES NO
3. Have you ever had a serious illness? YES NO
4. Has there been any change in your health in the last year? YES NO
5. Have you ever had surgery? (An operation) YES NO
Please indicate what type of surgery _____
6. Have you gained or lost much weight recently? YES NO
7. Have you ever been treated for ear or eye trouble, other than corrective glasses? YES NO
8. Do you bleed for a long time when you cut yourself? YES NO
9. Have you ever had hives or a skin rash? YES NO
10. Have you ever been told you have heart trouble? YES NO
11. Do you get out of breath easily? YES NO
12. Do you have spells of dizziness? YES NO
13. Do your ankles ever become badly swollen? YES NO
14. Do you have high blood pressure? YES NO
15. Have you ever been told that you have a heart murmur? YES NO
16. Do you have any blood disorder? YES NO
17. Do you have asthma, hay fever, sinusitis or frequent sore throat? YES NO
18. Have you ever had tuberculosis, emphysema or other lung disease? YES NO
19. Do you have stomach trouble, frequent diarrhea or constipation? YES NO
20. Have you ever been told you have kidney or bladder trouble? YES NO
21. Have you ever had syphilis or gonorrhea? YES NO
22. Do you ever have fits, convulsions or seizures? YES NO
23. Do you have arthritis or joint trouble? YES NO

24. Are your joints often painfully swollen? YES NO
25. Have you had a general or local anesthetic? YES NO
26. Have you often had toothaches? YES NO
27. Do your gums bleed when you brush your teeth? YES NO
28. Do your gums itch when you brush your teeth? YES NO
29. Does it hurt when you chew? YES NO
30. Do you have any problems with your jaws? YES NO
31. Do you clench or grind your teeth? YES NO
32. Have you ever had an injury to your face, neck or jaw? YES NO
33. Do you suffer from frequent or severe headaches, neck or back pain? YES NO
34. Have you ever received x-ray or radiation therapy to the head or neck? YES NO
35. Do you have ear pain or pain in front of the ears? YES NO
36. Does your jaw feel tired after a big meal? YES NO
37. Must you chew on one side exclusively? YES NO
38. Is your sleep disturbed by pain of the head and neck region? YES NO
39. Are your daily activities or routine disturbed by pain of the head and neck region? YES NO
40. Do you consider yourself a nervous person? YES NO
41. Do you fee unhappy or depressed? YES NO
42. Are you easily upset? YES NO
43. Are you sensitive or allergic to any medicine? YES NO
- Are you sensitive or allergic to any of the following?
- | | | | |
|-----------------|--------|---------------------|--------|
| Penicillin..... | YES NO | Novocain..... | YES NO |
| Aspirin..... | YES NO | Iodine..... | YES NO |
| Codeine..... | YES NO | Sleeping pills..... | YES NO |
- Other: _____
44. Do you smoke or use tobacco? YES NO
45. Do you drink alcohol daily? YES NO
46. WOMEN – Are you pregnant? YES NO
47. WOMEN – Are you in or have passed through menopause (change of life)? YES NO

When did you last have radiographs (Full Mouth X-rays – 18-20 images) taken?

(Month/Year) _____

List all Prescription and Non-Prescription drugs taken or used in the past 3 months:

List all hospitalizations for any reason:

Reason: _____

PATIENT SIGNATURE: _____

DATE: _____

Fullerton Dental Assistant School
2720 North Harbor Blvd. Suite #110
Fullerton Ca. 92835

CLINICAL PATIENT RELEASE FORM

I hereby give my permission for coronal polishing to be performed on me as part of clinical requirements for coronal polishing licensure.

I understand that no charge will be made for the service performed. In consideration thereof, I hereby agree to waive, release, hold harmless, defend and indemnify, as against any and all claims I or heirs may have now or in the future against its principals and/or agents, arising out of or resulting from my voluntary participation as a patient in this coronal polish course.

I have read and I understand the terms of this agreement.

Patient Name: _____

Signature: _____

Date: _____

Fullerton Dental Assistant School
2720 North Harbor Blvd. Suite #110
Fullerton Ca. 92835

PATIENT
CORONAL POLISH CALCULUS FREE FORM

Date: _____

Patient Name: _____ rendered calculus free.

The patient named above has been examined by a licensed dentist or hygienist and deemed calculus free. He/she is able to participate in a coronal polishing procedure.

Licensed Dentist Name or Hygienist Name: _____

Signature: _____