Contract of Affiliation - Participating Dentist's Agreement

(Practice-site) this is a student's place of employment where they are supervised by their employer, the participating dentist agree to:

- Provide lecture, laboratory and clinical instruction to the students prior to the student performing any radiographic techniques at the stated site.
- Provide both participating dentists (the dentist that will be overseeing the students practice in their home office) and students with criteria for an acceptable full mouth radiographic survey.

Participating Dentist Agrees:

- That the facility, where the student will be performing full mouth radiographic surveys on patients, meets and maintains all state requirements. I will assure that the participating student will not be interrupted; and the student will follow all radiation safety protocols while taking said exposure on each patient.
- Ensures that the student exposes a minimum of two full mouth radiographic surveys that are of diagnostic quality. Each survey should have a total of 18 films: four bitewings and 14 periapical radiographs. All exposure shall be made with size #2 double film packets
- There shall be no more than three retakes for each full mouth survey taken as homework.
- To evaluate the students full mouth radiographic survey with the Criteria sheet provided by Fullerton Dental Assistant School. The student will also be required to self-evaluate his or her work with the same criteria sheet.
- To maintain a medical history on any patient that had a full mouth set of radiographs performed on them.

Any Infraction of the above agreement by either party may result in termination of the above agreement. This agreement may also be terminated by either party for any reason, with a 30 day written notification.

A written ***Contract of Affiliation*** must be obtained before any radiographs can be performed by the students. This form must be completed and presented to the course instructor on the first day of class.

_____ is not responsible for workers compensation insurance or malpractice insurance for students assigned to this facility.

This is a mutual agreement between the offices of:

Participating Dentist Name: _____

Participating Dentist Signature: _____

License #: _____ Exp. Date: _____

Address: _____

City/State/ Zip: _____ Phone: _____

Students Name: _____ Date: _____

Student's Signature: _____

Fullerton Dental Assisting Program

Prescription for X-Ray

Doctor's Name:_____ License Number:_____

Street Address:_____

City:_____ Zip:_____ Phone:_____

E-mail address:_____ would you like to e-mail or mail your x-rays to you.

Please take_____ x-rays on my patient_____ for diagnostic purposes.

These x-rays are my property and a copy may be retained in Fullerton Dental Assisting Program files for no less than five years for licensure purposes for:

Student Name:_____

Doctor's Signature:_____

Date:_____

Fullerton Dental Assistant School

Radiographic Procedure

Patient Consent Form

I, _____, give authorization to have my x-rays of my body taken by _____, a dental assisting student of Fullerton Dental Assistant School, to satisfy his/her radiation health and safety certification requirements.

The full-mouth x-ray series will present periapical and bitewing radiographic exposures ("the x-rays"). 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 that the x-rays will be provided to me should be brought to a dentist to complete a dental examination and diagnosis. This x-rays are not being taken 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 x-rays, 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 x-ray 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 x-ray procedure or the Company's, or any of its employees', students' or agents' acts or omissions;

5. Agree to indemnify the Company, its affiliates, servants, agents or employees from any claims or demands which might be made against the Company arising out of or in consequence of the x-ray 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 X-RAY 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
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 feel 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: _____

Dental Radiography Full-Mouth Evaluation

Student _____

Date _____ Dxttr FMX No. _____

Patient FMX No. _____

Identify (✓ mark) technique and mounting method.

❑ Parallel Technique ❑ Bisecting Technique ❑ Convex Mounting ❑ Concave Mounting

Instructions to the Student:

1. Fill in the information at the top of the form: name, date, FMX number, technique, mounting method.
2. Evaluate each film beginning with number 1. Anatomy to be included in each image is indicated in the film box.
3. Using the numbers from the error list, mark your errors in the appropriate film box using a black or blue pen. There may be more than one error on a film.
4. Submit this form and BWX / FMX set to the instructor for grading. The instructor will identify corrective procedures using a red pen.
5. Fifteen or more of the eighteen films must be of diagnostic quality; a passing grade is a minimum of 75 points.

Error Categories:

1. Elongation
2. Foreshortening
3. Cone Cut
4. Overlapping
5. Film Bent
6. Dot Misplaced
7. Double Exposure
8. Herringbone/Diamond Pattern
9. Apices Missing
10. Coronal Portion Missing
11. Film Placed Off Center
12. Film Placed Too High
13. Film Placed Too Low
14. Film Placed Too Anterior
15. Film Placed Too Posterior
16. Film or Patient Movement
17. Exposure: mA, kVp or Time
18. Overdeveloped
19. Underdeveloped
20. Mismounted

1. Upper Molars	2. Upper Bicuspids	3. Upper Cuspid	4. Upper Centrals	5. Upper Cuspids	6. Upper Bicuspids	7. Upper Molars
Center 2nd Molar all molars present & distal of 2nd bicuspid	**Center 2nd Bicuspid** distal of cuspid & posterior teeth	**Center Cuspid** cuspid, lateral, portion of central & 1st bicuspid	**Center Midline** centrals & laterals	**Center Cuspid** cuspid, lateral, portion of central & 1st bicuspid	**Center 2nd Bicuspid** distal of cuspid & posterior teeth	**Center 2nd Molar** all molars present & distal of 2nd bicuspid

8. Molar Bitewing	9. Bicuspid Bitewing	10. Bicuspid Bitewing	11. Molar Bitewing
Center Mandibular 2nd Molar molars distal of 2nd bicuspid	**Center Mandibular** 2nd Bicuspid distal of cuspid & bicuspids	**Center Mandibular** 2nd Bicuspid distal of cuspid & bicuspids	**Center Mandibular** 2nd Molar molars distal of 2nd bicuspid

12. Lower Molars	13. Lower Bicuspids	14. Lower Cuspid	15. Lower Centrals	16. Lower Cuspids	17. Lower Bicuspids	18. Lower Molars
Center 2nd Molar all molars present & distal of 2nd bicuspid	**Center 2nd Biscuspid** distal of cuspid & posterior teeth	**Center Cuspid** cuspid, lateral portion of central & 1st bicuspid	**Center Midline** centrals & laterals	**Center Cuspid** cuspid, lateral, portion of central & 1st bicuspid	**Center 2nd Bicuspid** distal of cuspid & posterior teeth	**Center 2nd Molar** all molars present & distal of 2nd bicuspid

RADIOGRAPH GRADING CRITERIA

EXCELLENT RADIOGRAPHS—No points deducted.

1. No overlapping.
2. No cone cuts.
3. No foreshortening or elongation.
4. All apices visible on periapicals, including third molars.
5. Film placement—periapicals
   - Central and lateral incisors centered.
   - Cuspids centered.
   - Second bicuspid centered.
   - Second molar centered.
6. Film placement—bitewings
   - Mandibular second bicuspid centered on bicuspid bitewing.
   - Mandibular second molar centered on molar bitewing.

ACCEPTABLE RADIOGRAPHS

—minus 1 point per error on periapicals.
—minus 2 points per error on bitewings.

1. Slight overlapping—contact area visible on partner x-ray.
2. Slight cone cut—necessary anatomy not eliminated or visible on partner x-ray.
3. Slight foreshortening.
4. Slight elongation—apices must be visible.
5. All apices visible except for third molars.
6. Film placement—teeth not in ideal position but all teeth in oral cavity are present on FMX.

UNACCEPTABLE RADIOGRAPHS

—minus 5 points per error on periapicals.
—minus 6 points per error on bitewings.

1. All apices not visible.
2. Gross overlapping—all contact areas not visible.
3. Gross elongation or foreshortening.
4. Gross cone cut—necessary anatomy not present.
5. Film placement—all teeth present in oral cavity not present on film or incorrectly positioned.

Instructions to the Instructor:

1. Review student's self evaluation.
2. Use the grading criteria on the left to evaluate radiographs.
3. Points deducted for errors are to be subtracted from 100.
4. In the spaces below, indicate deductions, necessary retakes and the error category numbers for each film. Examples:

Film 1: Points -1 Retake Yes (No) Error Number(s) 4

Film 2: Points -0 Retake Yes (No) Error Number(s) None

Film 3: Points -10 Retake (Yes) No Error Number(s) 1,4

5. Return to student for retakes, if necessary.
6. File in student's record.

1. Points____Retake Yes No Error Number(s)____
2. Points____Retake Yes No Error Number(s)____
3. Points____Retake Yes No Error Number(s)____
4. Points____Retake Yes No Error Number(s)____
5. Points____Retake Yes No Error Number(s)____
6. Points____Retake Yes No Error Number(s)____
7. Points____Retake Yes No Error Number(s)____
8. Points____Retake Yes No Error Number(s)____
9. Points____Retake Yes No Error Number(s)____
10. Points____Retake Yes No Error Number(s)____
11. Points____Retake Yes No Error Number(s)____
12. Points____Retake Yes No Error Number(s)____
13. Points____Retake Yes No Error Number(s)____
14. Points____Retake Yes No Error Number(s)____
15. Points____Retake Yes No Error Number(s)____
16. Points____Retake Yes No Error Number(s)____
17. Points____Retake Yes No Error Number(s)____
18. Points____Retake Yes No Error Number(s)____

Total deduction: _____ Number of retakes needed: _____ Number of diagnostic films: _____

(15 or more of the 18 films must be of diagnostic quality)

Pass: Yes ❑ No ❑ Total Points: _____ Instructor Signature: _____

I _____ have evaluated my radiographs appropriately.
Print Name

_____.
Signature

INSTRUCTIONS TO CALIFORNIA RDA STUDENTS ONLY:

1. After reaching manikin (DXTTR) proficiency in radiographic techniques, you will be required to take a full mouth set of films on four patients.
2. You will be responsible for recruiting each patient.
3. Provide your instructor with your patient's Rx (prescription) from their dentist.
4. Include your patient's name in the space provided below.

Patient Name (1) _____

Patient Name (2) _____

Patient Name (3) _____

Patient Name (4) _____

Submit