PATIENT AGREEMENT

Patient Name: _____ Date:_____

1. Oxnard College Dental Hygiene Program is a teaching institution with its main purpose to educate and graduate qualified dental hygiene practitioners. As a patient, you are an essential and welcome part of the teaching program. While students wear nametags reading "Oxnard College Dental Hygiene Student" this does not designate them as licensed professionals. All patients are assigned to qualified students, who render dental hygiene treatment under the close supervision of a clinical staff dentist and faculty.

2. I understand that:
    a. Oxnard College is a dental hygiene teaching facility and is only a component of my oral health care. I must have a primary care dentist outside of the facility for complete oral health care. I understand there is no guarantee that I can be accommodated for regular recall intervals, and I may need to see my primary dentist for ongoing care.
    b. I am responsible for full payment of each procedure prior to the start of that procedure.
    c. Oxnard College reserves the right to revise fees for treatment at any time for any procedure that has not been started.
    d. I understand that I must give at least 24 hours' notice if I change an appointment. Any appointment canceled or rescheduled with less than 24 hours' notice is considered a broken appointment. Three broken appointments and treatment will be discontinued.
    e. I understand that it is the decision of the faculty to accept or reject patients at ANY TIME.
    f. All records pertinent to diagnosis and treatment of patients become the property of Oxnard College, although information contained in these records is available to patients. There is a fee for printed copies of x-rays and/or records.
3. The Oxnard College Dental Clinic does not accept MediCal or insurance of any kind. Credit card payments must be made through the Oxnard College Student Business Office 805-678-5811
4. I hereby authorize Oxnard College to use pictures taken of me during treatment. It is understood and agreed that my name will not be used without my permission or in any way disclosed in connection therewith.
5. I grant permission to Oxnard College to expose any necessary x-rays, administer anesthetics, remove any tissue and/or structure, and to employ such operative and technical procedures as are necessary or advisable for the diagnosis and treatment of the patient below.
6. I will immediately report any change in my health; if I have been hospitalized, consulted a physician, been sick, or have taken or am taking any new drug or medication in addition to those already reported on my medical history.

By signing below, I acknowledge that I have read, understand, and agree to abide by the clinic policies and procedures. I certify that I am the patient, the patient's parent or guardian, or an authorized general agent with the legal authority to execute this agreement and accept its terms.

_____ _____

Patient Signature (if a minor) Parent or Guardian Signature Date

Parent or Guardian's Name: _____

Relationship: _____