PATIENT AGREEMENT

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. Students are designated with a nametag preceded by Oxnard College Dental Hygiene Student. However, this is not done to represent them as licensed dental hygienists. All patients are assigned to qualified students who render dental hygiene treatment under the close supervision of a clinical staff dentist and faculty.

The undersigned hereby acknowledges that they have read, understand, and agree to abide by the policies and procedures provided on this form.

1. 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 this facility for complete oral health 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. If 24 hours notice is not given, this will be 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.
2. The Oxnard College Dental Clinic does not accept MediCal or insurance of any kind. Credit card payments must be made at the Oxnard College Student Business Office (patient must bring receipt to appointment as proof of payment).
3. I grant permission to Oxnard College to expose any necessary x-rays, administer anesthetics, use intraoral pictures, and to employ such operative and technical procedures as are necessary or advisable for the diagnosis and treatment of the below patient.
4. 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.

The undersigned certifies that he/she has read and is willing to comply with the foregoing, and is the patient, the parent or guardian of the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient Signature: _____ Date_

MINORS ONLY:

Parent or Guardian's Name (PRINT):_____ Date_____

Parent or Guardian Signature: _____ Relationship to Patient: _____