ANNE ARUNDEL COMMUNITY COLLEGE

School of Health Sciences - Dental Hygiene Clinic
Health and Life Sciences Building (HLSB), Room 137
101 College Parkway, Arnold, MD 21012 Phone: 410-777-7213

Welcome to the AACC Dental Hygiene Clinic

Thank you for choosing the Anne Arundel Community College Dental Hygiene Clinic for your oral healthcare needs. Our clinic is an educational facility where dental hygiene students provide care under the direct supervision of licensed dental professionals.

This packet contains important information and required forms related to:
- Medical and dental history
- Privacy practices and acknowledgments
- Consent for treatment and assessments
- Financial policies and fees
- Patient rights and responsibilities
- Appointment policies
- Communication and interpreter services
- Student/observer presence

Please review each document carefully and complete all required sections. These forms help ensure safe, effective, and respectful care while supporting the education of future dental professionals.

Patient Information
Patient Name: _____
Date of Birth: _____
Date Packet Completed: _____

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MEDICAL / DENTAL HISTORY FORM

Patient Information

Full Legal Name: _____

Preferred Name (if different): _____

Date of Birth (MM/DD/YYYY): _____

Age: _____

Gender Identity:

☐ Male
☐ Female
☐ Nonbinary
☐ Prefer to self-describe: _____
☐ Prefer not to answer

Pronouns:

☐ She/Her
☐ He/Him
☐ They/Them
☐ Other: _____

Contact Information

Home Address: _____

City: _____ State: _____ ZIP Code: _____

Primary Phone: _____ Type: Mobile / Home / Work

Secondary Phone: _____ Type: Mobile / Home / Work

Email Address: _____

Preferred Method of Contact:

☐ Phone
☐ Email

☐ Text Message
☐ Postal Mail

Emergency Contact

Emergency Contact Name: _____

Relationship to Patient: _____

Phone Number: _____

Alternate Phone: _____

Ethnicity & Race

Hispanic or Latino?

☐ Yes
☐ No
☐ Prefer not to answer

Race (select all that apply):

☐ American Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Other: _____
☐ Prefer not to answer

Language & Communication Needs

Primary Language Spoken: _____

Preferred Language for Care: _____

Do you need an interpreter? Yes / No

If yes, which language? _____

Access & Accommodations

☐ Mobility assistance (wheelchair, walker, etc.)
☐ Vision support
☐ Hearing support

☐ Cognitive or communication assistance
☐ Other accommodations: _____

Consent & Communication

May we leave voicemails regarding appointments? Yes / No

May we send text reminders? Yes / No

May we share treatment information with an authorized individual? Yes / No

If yes, Name/Relationship: _____

Dental History

Reason for visit today: _____

Date of last dental visit: _____

Last dental cleaning date: _____

Last full-mouth X-ray date: _____

What was done during your last dental visit? _____

Previous dentist's name: _____

Contact number: _____

Address (including state and ZIP): _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____

How often do you floss? _____

Have you ever used topical fluoride? Yes / No

Dental aids used: _____

Any current dental problems? Yes / No

Tooth Sensitivity & Oral Habits

Sensitive to hot/cold: Yes / No

Sensitive to sweets: Yes / No

Sensitive when biting or chewing: Yes / No

Mouth odors or bad taste: Yes / No

Cold sores or blisters: Yes / No

Gums bleed or hurt: Yes / No

Parental gum disease/tooth loss: Yes / No

Loose teeth or bite changes: Yes / No

Food caught between teeth: Yes / No

Clenching or grinding: Yes / No

Biting lips or cheeks: Yes / No

Holding objects with teeth: Yes / No

Mouth breathing: Yes / No

Tired jaws in the morning: Yes / No

Snoring or sleep disorders: Yes / No

Alcohol consumption: Yes / No

Recreational drugs: Yes / No

Use of vaping device: Yes / No

Tobacco use (smoke/chew): Yes / No

Previous Dental Treatments

Orthodontic treatment: Yes / No

Periodontal treatment: Yes / No

Oral surgery: Yes / No

Bite plate or mouth guard: Yes / No

Bite adjusted: Yes / No

Serious injury to mouth/head: Yes / No

Jaw Joint (TMJ) Symptoms

Clicking or popping: Yes / No

Joint/ear/face pain: Yes / No

Difficulty opening/closing mouth: Yes / No

Chewing difficulty on one side: Yes / No

Headaches/neck aches: Yes / No

Neck/shoulder muscle soreness: Yes / No

Medical History

Medical care within past year: Yes / No

Medications in past two years: Yes / No

Currently taking medications: Yes / No

Prescription weight-loss medications: Yes / No

Bone loss prevention drugs: Yes / No

Allergic reactions: Yes / No

Hospital patient: Yes / No

Medical Conditions Checklist

Heart disease/attack: Yes / No

Heart surgery: Yes / No

Artificial heart valve: Yes / No

Pacemaker: Yes / No

Congenital heart disease: Yes / No

Heart murmur: Yes / No

High/low blood pressure: Yes / No

High cholesterol: Yes / No

High triglycerides: Yes / No

Chest pain: Yes / No

Rheumatic fever: Yes / No

Asthma: Yes / No

Arthritis/rheumatism: Yes / No

Cortisone medicine: Yes / No

Latex sensitivity: Yes / No

Swollen ankles: Yes / No

Stroke: Yes / No

Artificial joints: Yes / No

Tumors: Yes / No

Radiation therapy: Yes / No

Chemotherapy: Yes / No

Ulcers: Yes / No

Thyroid problems: Yes / No

Glaucoma: Yes / No

Emphysema: Yes / No

Chronic cough: Yes / No

Tuberculosis: Yes / No

Neurological disorders: Yes / No

Hay fever/allergies: Yes / No

Epilepsy/seizures: Yes / No

Fainting/dizziness: Yes / No

Sinus trouble: Yes / No

Digestive disorder: Yes / No

GERD: Yes / No

Anxiety: Yes / No

Psychiatric care: Yes / No

Venereal disease: Yes / No

Diabetes I/II: Yes / No

Special diet: Yes / No

Cold sores/fever blisters: Yes / No

AIDS/HIV positive: Yes / No

Blood transfusion: Yes / No

Hemophilia: Yes / No

Sickle cell disease: Yes / No

Bruise easily: Yes / No

Liver disease: Yes / No

Kidney trouble: Yes / No

Hepatitis A/B/C: Yes / No

Additional Information

Familial history of diabetes, tumors, or cardiovascular ailments:

_____

Lost or gained more than 10 lb in the past year? Yes / No

Any disease or condition not listed? Yes / No

Pregnant? Yes / No

Nursing? Yes / No

Months pregnant (if applicable): _____

Using birth control prescriptions? Yes / No

Signatures

Patient signature: _____ Date: _____

Parent/guardian signature (for minors): _____ Date: _____

Dental hygiene student: _____

Dental hygiene student signature: _____

Attending dentist signature: _____ Date: _____

Blood pressure: _____

Pulse: _____

Respirations: _____

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Notice of Privacy Practices

Effective Date: January 1, 2026

This notice describes how your medical and dental information may be used and disclosed, and how you can access that information. Please review it carefully.

Our Legal Duty

- Maintain the privacy of your health information;
- Provide you with this notice explaining our legal duties and privacy practices;
- Notify you if a breach occurs involving your health information; and
- Follow the terms of this notice, as updated from time to time.

How We May Use and Disclose Your Information

1. Treatment

To provide, coordinate, or manage your dental care and related services.
Example: sharing necessary information with supervising dentists, faculty, or students involved in your treatment.

2. Health Care Operations

For educational, administrative, accreditation, quality improvement, and compliance purposes.
Example: using de-identified information to assess student performance or improve patient services.

Other Uses and Disclosures Permitted or Required by Law

- Public Health Activities (disease prevention, infection control, product recalls)
- Health Oversight Agencies (audits, licensure, or accreditation review)
- Law Enforcement or Legal Requirements (court orders, subpoenas, reporting of suspected abuse)
- Workers' Compensation (as required by applicable laws)
- Coroners, Medical Examiners, or Organ Procurement (for identification or donation purposes)
- Serious Threat to Health or Safety (to prevent harm to yourself or others)
- National Security or Armed Forces (if applicable under federal law)

Other Uses Requiring Your Written Authorization

- Marketing, photographs, or social-media materials

- External teaching or case presentations outside AACC's covered entity
- Research projects not approved through AACC's Institutional Review Board (IRB)
- Sale of health information

You may revoke an authorization at any time in writing.

Your Rights Regarding Your Health Information

- Inspect and Obtain Copies – Request to view or receive a copy of your clinical or billing records.
- Request a Correction – Ask us to correct information you believe is incomplete or inaccurate.
- Request Restrictions – Ask us to limit the use or disclosure of your information. (We may not be able to agree to all requests.)
- Confidential Communications – Request that we contact you at a specific address, phone number, or email.
- Accounting of Disclosures – Request a list of disclosures made for reasons other than treatment, payment, or operations.
- Paper or Electronic Copy of This Notice – You may request a paper copy at any time, even if you received it electronically.
- File a Complaint – You may file a complaint if you believe your privacy rights have been violated.

To AACC: Email: privacy@aacc.edu Phone: 410-777-4357

To the U.S. Department of Health and Human Services (HHS):

Office for Civil Rights, 200 Independence Ave SW, Washington DC 20201
Phone: 1-877-696-6775 | www.hhs.gov/ocr/privacy/hipaa/complaints

There will be no retaliation for filing a complaint.

Changes to This Notice

We reserve the right to revise or update this notice at any time. A current copy will always be posted in the clinic reception area and on the AACC website. Changes will apply to all information we maintain, including information created or received before the revision date.

Contact for Questions

If you have questions about this notice, please contact:

privacy@aacc.edu Phone: 410-777-4357Acknowledgment of Receipt: Patients will be asked to sign the Notice of Privacy Practices – Acknowledgment Form confirming they have received or reviewed this notice.

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NOTICE OF PRIVACY PRACTICES (NPP) – ACKNOWLEDGMENT

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

Section 1 – Purpose

The Maryland Confidentiality of Medical Records Act requires Anne Arundel Community College (AACC) to protect the privacy of your health information.

The NPP describes how your health information may be used or disclosed for treatment, payment, and healthcare operations, and explains your rights regarding that information.

This form documents that you have received or were offered a copy of AACC's NPP.

Section 2 – Acknowledgment of Receipt (Please check the appropriate box.)

☐ I acknowledge receipt of the AACC Dental Hygiene Clinic's Notice of Privacy Practices.

☐ I declined a copy of the Notice of Privacy Practices but understand it is available upon request at any time.

☐ I was offered a copy of the Notice of Privacy Practices and chose to review it online at:(final web address to be added)

Section 3 – Summary of Patient Rights

- I have the right to inspect, copy, and request corrections to my health information.
- I may request restrictions on certain uses or disclosures of my information.
- I may request confidential communication or alternative contact methods.
- I may file a complaint with privacy@aacc.edu or with the U.S. Department of Health and Human Services (HHS) if I believe my privacy rights have been violated.

Section 4 – Signature

By signing below, I acknowledge that I have read and understood the information above and that I have received, been offered, or had access to review AACC's Notice of Privacy Practices.

Patient / Legal Guardian Signature: _____

Date: _____

Printed Name (if guardian): _____

Relationship to Patient: _____

Section 5 – Clinic Use Only

Staff Member Providing Notice: _____

Date Provided: _____

Patient Declined to Sign: ☐ Yes ☐ No

Reason (if applicable): _____

Notes: _____

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CONSENT FOR TREATMENT IN AN EDUCATIONAL SETTING

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

Section 1 – Purpose

The AACC Dental Hygiene Clinic is a teaching facility.

Your care is provided by dental hygiene students under the direct supervision of licensed dental hygienists and dental professionals who ensure safe and appropriate treatment. This form documents your informed consent to receive dental care in a supervised, educational environment.

Section 2 – Description of Services

Treatment may include—but is not limited to—the following:

- Comprehensive oral evaluations and radiographs
- Preventive services (cleanings, fluoride, sealants)
- Periodontal assessments and therapy
- Restorative or assisting procedures as indicated
- Oral hygiene and self-care instruction
- Local anesthesia or desensitizing agents (as appropriate)

All procedures are reviewed and approved by supervising faculty or dentists before and after completion.

Section 3 – Patient Understanding (Please initial each to acknowledge.)

- I understand that care is provided by dental hygiene students for the purpose of clinical education and skill development. Initials _____
- All students are supervised by licensed faculty and/or dentists, and treatment plans are reviewed for quality and safety. Initials _____
- I understand that additional appointments may be required because this is a teaching environment, and visits may take longer than in private practice. Initials _____
- I understand that participation is voluntary, and I may refuse or discontinue treatment at any time. Initials _____

- I understand I have the right to ask questions about my treatment, the risks and benefits, and any alternatives. Initials _____
- I understand that the AACC Dental Hygiene Clinic complies with all applicable infection control and state privacy laws. Initials _____

Section 4 – Risks and Benefits

Dental procedures, like all health services, carry certain risks such as discomfort, bleeding, tissue irritation, or post-treatment sensitivity. The benefits include improved oral health, disease prevention, and educational support to future dental professionals. All reasonable steps are taken to minimize risks and ensure safe care.

Section 5 – Consent and Signature

By signing below, I acknowledge that:

- I have read and understand the information above.
- I consent to receive dental treatment provided by AACC dental hygiene students under licensed supervision.
- I authorize the use of my information for educational and clinical documentation within AACC's Dental Hygiene Clinic.

Patient / Legal Guardian Signature: _____ Date: _____

Printed Name (if guardian): _____

Relationship to Patient: _____

Section 6 – Witness / Program Use Only

Witness (Faculty/Staff): _____ Date: _____

Notes: _____

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GENERAL INFORMED CONSENT FOR ORAL HEALTH ASSESSMENT – VISIT 1

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

Section 1 – Purpose

The AACC Dental Hygiene Clinic is an educational facility that provides comprehensive oral health assessments and diagnostic services performed by dental hygiene students under the supervision of licensed dental faculty and dentists. This consent covers initial assessment procedures only—no treatment will be rendered during this visit.

Section 2 – Scope of Assessment

- Review of medical and dental history
- Extra and intra-oral examination (head, neck, oral cavity)
- Periodontal and soft-tissue charting
- Occlusal and restorative evaluation
- Diagnostic radiographs (bitewing, periapical, or panoramic)
- Intraoral photographs (for diagnostic or educational purposes)
- Oral hygiene evaluation and self-care instruction

All findings will be reviewed by the supervising licensed dentist or dental hygiene faculty and may be used to determine future treatment needs.

Section 3 – Patient Understanding

- I understand that today's appointment is limited to oral assessment and diagnostic imaging; no operative or preventive treatment will be performed.
- I understand that procedures are performed by dental hygiene students under the direct supervision of licensed dentists and dental hygiene faculty.
- I have the right to ask questions regarding the nature and purpose of these assessments and have received satisfactory answers.
- I understand that radiographs are taken only when deemed necessary for diagnostic purposes, using equipment that meets all Maryland radiation-safety standards.
- I understand that my participation is voluntary and that I may withdraw my consent at any time.

- I understand that all information collected is confidential and maintained in compliance with applicable state privacy laws and AACC privacy policies.

Section 4 – Risks and Benefits

Potential Risks: Temporary tissue discomfort, minor gagging, or light exposure to diagnostic radiation (well below federal safety limits).

Benefits: Comprehensive evaluation of oral and periodontal health, early detection of conditions, and eligibility for future preventive or restorative care at the AACC Dental Hygiene Clinic.

Section 5 – Consent to Assessment

By signing below, I acknowledge that:

- I have read and understood the information above;
- I consent to an oral health assessment and diagnostic radiographs performed by AACC dental hygiene students under the supervision of licensed dentists and dental hygiene faculty;
- I authorize AACC to use and store my diagnostic records for educational and clinical documentation purposes within its Dental Hygiene Clinic.

Patient / Legal Guardian Signature: _____ Date: _____

Printed Name (if guardian): _____

Relationship to Patient: _____

Section 6 – Witness / Program Use Only

Witness (Faculty/Staff): _____ Date: _____

Notes: _____

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FINANCIAL POLICY & FEE ACKNOWLEDGMENT

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

Section 1 – Purpose

The AACC Dental Hygiene Clinic operates as a teaching facility, providing quality oral health services performed by dental hygiene students under the supervision of licensed dental professionals. Clinic fees are significantly reduced compared to private practice rates because treatment times may be longer and services are provided in an educational environment. This form outlines our financial policies and confirms your understanding of all associated fees.

Section 2 – Payment Policy

- I understand that all services rendered by the AACC Dental Hygiene Clinic will not be billed to dental insurance and are offered at a reduced educational rate.
- Payment is due at the time of service.
- Acceptable forms of payment include credit/debit card or text-to-pay (no cash transactions accepted).
- A receipt for all payments will be provided.
- I understand that fees may vary depending on the type and complexity of treatment and will be discussed before services are rendered.
- I understand that failure to pay for services may result in suspension of future appointments until the balance is resolved.

Section 3 – Fee Statement

A full, up-to-date fee schedule is posted in the clinic and available online at the AACC Dental Hygiene Clinic webpage. Fees are subject to change and will be reviewed with the patient before services begin.

Section 4 – Refunds and Credits

Patients may prepay for their treatment; however, for any prepaid treatment plans, refunds will not be issued. Refunds are provided only for billing errors or for procedures canceled before the start of treatment. All fees are due on the date of treatment prior to the start of treatment.

Section 5 – Acknowledgment

By signing below, I acknowledge that:

- I have reviewed and understand AACC Dental Hygiene Clinic's Financial Policy and Fee Acknowledgment;
- I agree to be responsible for all fees associated with my care;
- I have received an explanation of available payment methods; and
- I understand this policy applies to all future visits unless updated by AACC.

Patient / Legal Guardian Signature: _____ Date: _____

Printed Name (if guardian): _____

Relationship to Patient: _____

Section 6 – Clinic Use Only

Reviewed by (Faculty/Staff): _____ Date: _____

Notes: _____

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PHOTOGRAPHY / RECORDING BAN

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

Section 1 – Purpose

To protect patient privacy and ensure compliance with applicable state privacy laws, the use of personal cameras, phones, tablets, or recording devices in the clinical and radiographic areas of the AACC Dental Hygiene Clinic is strictly prohibited. This form documents patient acknowledgment of the clinic-wide ban on photography and recording.

Section 2 – Photography / Recording Prohibition

I understand that photography, video, or audio recording of any kind within the AACC Dental Hygiene Clinic is not permitted. This includes images or recordings of patients, students, faculty, staff, equipment, or any clinical activities.

Section 3 – Conditions

- No personal images or recordings may be taken or shared within the AACC Dental Hygiene Clinic.
- Unauthorized photography, recording, or distribution may result in disciplinary action, removal from the clinic, or legal consequences in accordance with AACC policy and applicable law.

Section 4 – Acknowledgment

I acknowledge that I have read and understand this Photography/Recording Ban policy and agree to comply with it while receiving care in the AACC Dental Hygiene Clinic.

Important Note:
This form does not grant permission for photography.

Signature: _____ Date: _____

Printed Name (if parent/legal guardian): _____

Relationship to Patient: _____

4933-7369-3067

Section 5 – Office Use Only

Processed by: _____ Date: _____

Notes: _____

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PATIENT RIGHTS & RESPONSIBILITIES

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

Section 1 – Purpose

The AACC Dental Hygiene Clinic is a teaching facility providing high-quality care in a professional, safe, and respectful learning environment. This form outlines your rights as a patient and the responsibilities expected of all individuals receiving care in our educational clinic.

Section 2 – Patient Rights

- Respect & Dignity: Be treated with courtesy, compassion, and professionalism regardless of age, race, gender, disability, or background.
- Privacy: Expect confidentiality of your health information in compliance with applicable state privacy laws.
- Information: Receive explanations about your diagnosis, recommended procedures, potential risks, and alternatives.
- Informed Consent: Give voluntary consent before any treatment or procedure is started.
- Refusal of Care: Refuse any procedure and be informed of potential consequences.
- Access to Records: Request copies or review your dental records consistent with applicable state privacy laws.
- Interpreter Services: Receive language or sign-language assistance free of charge. Interpreter availability may require advanced scheduling, and appointments may be adjusted to ensure appropriate support.
- Chaperone Option: Request a chaperone or support person during examinations or procedures.
- Safe Environment: Expect an atmosphere free of harassment, discrimination, or abuse.

Section 3 – Patient Responsibilities

- Provide Accurate Information: Report complete and truthful health, medication, and dental-history details.

- Punctuality: Arrive on time and provide at least 24 hours' notice if you must cancel or reschedule an appointment.
- Respectful Conduct: Treat students, faculty, staff, and other patients with courtesy and respect at all times.
- Infection-Control Cooperation: Follow all clinic infection-control protocols (hand hygiene, protective eyewear, pre-procedural rinses, etc.).
- Photography & Recording: Refrain from taking photos, videos, or audio recordings within clinic areas.
- Children & Minors: Minors must be accompanied by a parent or legal guardian who remains on-site during care unless otherwise approved.
- Chaperone Policy: Understand that a faculty or staff chaperone may be present during certain procedures for safety and educational purposes.
- Financial Responsibility: Pay applicable fees at the time of service in accordance with the clinic's Financial Policy.
- Cooperation in Care: Follow recommended homecare and treatment instructions to achieve optimal oral-health outcomes.

Section 4 – Acknowledgment

- I have received and reviewed the AACC Dental Hygiene Clinics' Patient Rights & Responsibilities documented above.
- I understand the expectations for conduct, punctuality, infection-control cooperation, and photography restrictions.
- I agree to abide by clinic policies to support a professional and respectful educational environment.
- I understand that violations of these expectations may result in dismissal from the clinic or discontinuation of services.

Section 5 – Signatures

Patient / Legal Guardian Signature: _____ Date: _____

Printed Name (if guardian): _____

Relationship to Patient: _____

Section 6 – Clinic Use Only

Reviewed by (Faculty/Staff): _____ Date: _____

Notes: _____

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MISSED / LATE APPOINTMENT POLICY ACKNOWLEDGMENT

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

Section 1 – Purpose

The AACC Dental Hygiene Clinic operates within an educational environment. Because students' clinical experiences depend on scheduled patient care, it is essential that all patients arrive on time and honor their appointment commitments.

This form outlines the expectations and consequences related to missed, late, or cancelled appointments.

Section 2 – Policy Overview

- Timeliness: I understand that I am expected to arrive at least 10 minutes prior to my scheduled appointment time.
- Late Arrival: If I arrive more than 15 minutes late, I may be asked to reschedule my appointment at the discretion of clinic staff or faculty.
- Missed Appointment: Failure to notify the clinic of cancellation at least 24 hours in advance will be considered a missed appointment.
- Repeated Cancellations: Repeated missed or late cancellations may result in discontinuation of scheduling privileges at the AACC Dental Hygiene Clinic.
- Communication: I agree to contact the clinic as soon as possible if I need to cancel, reschedule, or anticipate being late.
- Courtesy Reminder: I understand that appointment reminders may be sent via text, email, or phone, but it remains my responsibility to remember my appointment.
- Educational Impact: I understand that my cooperation directly supports student learning and professional development, and I agree to help maintain a respectful and reliable clinical environment.

Section 3 – Acknowledgment

By signing below, I acknowledge that I have read, understood, and agreed to follow the AACC Dental Hygiene Clinic Missed / Late Appointment Policy as noted above.

Patient/Legal Guardian Signature: _____ Date: _____

Printed Name (if guardian): _____

Relationship to Patient: _____

Section 4 – Clinic Use Only

Reviewed by (Faculty/Staff): _____ Date: _____

Notes: _____

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CONSENT FOR STUDENT / OBSERVER PRESENCE

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

Section 1 – Purpose

The AACC Dental Hygiene Clinic operates within a supervised educational environment. Dental Hygiene students, as well as approved observers (such as visiting faculty, pre-dental hygiene students, pre-dental students, or healthcare trainees), may be present during clinical treatment sessions for the purpose of education, training, or program evaluation. This form documents your consent for students and/or observers to be present during your care in the AACC Dental Hygiene Clinic.

Section 2 – Consent Options (Please check the appropriate circle.)

☐ Full Consent – I consent to the presence of AACC students and/or observers during all or part of my dental treatment and understand that students will participate under the direct supervision of licensed faculty and supervising dentists.

☐ Limited Consent – I consent to student/observer presence for educational observation only, but do not authorize active participation in my care.

☐ No Consent – I do not consent to the presence of any students or observers during my treatment session. Please note: refusal will significantly limit scheduling availability and may preclude treatment in the AACC Dental Hygiene Clinic.

Section 3 – Acknowledgment

- Students and observers are bound by the AACC Dental Hygiene Clinic's privacy, conduct, and compliance standards.
- Licensed faculty and supervising dentists will always be present during treatment procedures.
- I may withdraw or modify this consent at any time by providing written notice to AACC Dental Hygiene Clinic administration.
- My decision will not affect the quality of my care; however, declining student or observer presence may significantly limit appointment availability.

Section 4 – Signatures

Patient/Legal Guardian Signature: _____ Date: _____

4908-4872-1803

Printed Name (if guardian): _____

Relationship to Patient: _____

Section 5 – Witness / Program Use Only

Witness (Faculty/Staff): _____ Date: _____

Role/Title: _____

Notes: _____

ANNE ARUNDEL COMMUNITY COLLEGE

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COMMUNICATION CONSENT FORM

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

Phone (Cell): _____ Alternate: _____

Email: _____

Section 1 – Purpose

The AACC Dental Hygiene Clinic uses various methods to communicate appointment reminders, scheduling updates, and limited clinical notifications. This form documents your consent to receive communications in compliance with applicable state privacy laws and AACC's communication policies.

Section 2 – Methods of Communication (Please check the appropriate box. You may select more than one.)

☐ Text Messaging – I consent to receive appointment reminders, confirmations, and brief clinic updates via text message to the number listed above. (Standard message and data rates may apply.)

☐ Email Communication – I consent to receive appointment reminders, forms, and educational information via email at the address listed above.

☐ Phone Calls / Voice Messages – I consent to receive phone calls or voicemail messages, including calls made through automated dialing or using recorded messages, regarding appointments, cancellations, or follow-up care.

Section 3 – Understanding and Limitations

- I understand that while the AACC Dental Hygiene Clinic uses secure systems, electronic communication (text/email) may involve some privacy risks.
- I understand that the AACC Dental Hygiene Clinic will not transmit clinical findings, diagnosis details, or health information via text or standard email.
- I understand that I may revoke or change my communication preferences at any time by notifying the clinic in writing.
- I agree to keep my contact information updated to ensure timely communication.

- I understand that appointment reminders are a courtesy, and it remains my responsibility to attend or cancel my scheduled appointment.

Section 4 – Consent and Signature

By signing below, I acknowledge that:

- I have read and understand the AACC Dental Hygiene Clinic's Communication Consent Form;
- I authorize the AACC Dental Hygiene Clinic to contact me according to the preferences I selected above;
- This consent will remain in effect until revoked or updated in writing.

Patient / Legal Guardian Signature: _____ Date: _____

Printed Name (if guardian): _____

Relationship to Patient: _____

Section 5 – Clinic Use Only

Reviewed by (Faculty/Staff): _____ Date: _____

Notes: _____

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School of Health Sciences - Dental Hygiene Clinic
Health and Life Sciences Building (HLSB), Room 137
101 College Parkway, Arnold, MD 21012 Phone: 410-777-7213

INTERPRETER / LANGUAGE SERVICES DISCLOSURE & CONSENT

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

Preferred Language: _____

English Proficiency Level: ☐ Fluent ☐ Limited

Section 1 – Purpose

The AACC Dental Hygiene Clinic is committed to providing equitable communication access for all patients. Patients with limited English proficiency (LEP) or hearing/speech impairments are entitled to interpreter services at no cost.

This form documents that language-assistance services were offered and records the patient's choice to accept or decline interpreter support.

Section 2 – Interpreter Service Options (Please check all that apply.)

☐ Professional Interpreter Provided by AACC – I accept the use of a qualified interpreter provided through AACC or an approved language-service vendor (on-site, phone, or video).

- ☐ ASL
- ☐ Spanish
- ☐ Other: _____

☐ Family Member / Friend Interpreter – I choose to use my own interpreter (family member, friend, or personal contact) and understand that AACC staff may request a professional interpreter if needed to ensure accuracy and safety.

☐ Decline Interpreter Services – I decline interpreter or translation services and confirm that I understand and can communicate effectively in English regarding my dental care.

Section 3 – Acknowledgment

- I understand that interpreter services are available free of charge to assist in my communication with AACC Dental Hygiene Clinic students, faculty, and staff.
- I understand that interpreter services help ensure accurate understanding of treatment explanations, risks, benefits, and forms of consent.

- If I choose to decline professional interpreter services, I accept responsibility for any miscommunication that may occur as a result.
- I may change my decision and request interpreter services at any time; however, I understand that certain interpreter services require advance scheduling and my appointment may need to be adjusted to ensure availability.
- The AACC Dental Hygiene Clinic will document the use or refusal of interpreter services in my patient record in accordance with applicable federal and state laws and AACC policy.

Section 4 – Consent and Signature

By signing below, I acknowledge that interpreter or language-assistance services have been explained to me, and I have indicated my preference above.

Patient / Legal Guardian Signature: _____ Date: _____

Printed Name (if guardian): _____

Relationship to Patient: _____

Section 5 – Clinic Use Only

Interpreter Name / ID #: _____

Language Provided: _____ Mode: ☐ On-Site ☐ Phone ☐ Video

Interpreter Company (if applicable): _____

Faculty/Staff Witness: _____ Date: _____

Notes: _____