Dental Hygiene Patient Consent, Disclosure, and Assumption of Responsibility

Candidate Sequential:____
Candidate ID:____
PLACE ID LABEL HERE
Test Site:____

Cubicle# [ ]

I authorize the individual listed below (the "Candidate") to perform the following procedure(s) during the administration by the Commission on Dental Competency Assessments (the "CDCA") of a dental hygiene licensing examination (the "Examination"):

☐ **Patient Treatment Clinical Examination**

Acknowledgment

I understand the following:

- that the Candidate may not be a licensed dental hygienist. (The State Board has not yet determined whether the Candidate has the requisite skills to attain a license.)
- that the CDCA has no knowledge of the Candidate's skill or competence, and makes no promises about them.
- that any arrangements between the Candidate and me regarding my serving as a patient (including any financial arrangements) are solely between the Candidate and me, and do not involve the CDCA in any way.
- that the CDCA has no duty to, and will not, notify me of inadequate work done by the Candidate during the Examination.
- that it is my responsibility to have any and all dental work performed by the Candidate checked by a licensed dentist to determine that it is satisfactory.

Disclosure of Risks

The Candidate has explained to me the risks involved in the procedures the Candidate will perform on me. The nature and purpose of the dental hygiene procedure(s), as well as the risks and possible complications, have been explained to me to my satisfaction by the Candidate. My questions with regard to the dental procedure(s) have been answered.

Adequacy of Treatment

I understand that the treatment provided during the Examination does not necessarily fulfill all my oral health needs, may not be performed correctly, or may not represent my entire treatment plan, and that further treatment may be necessary. I have been informed of the availability of services to complete treatment.

Authorization of Disclosure of Medical Information

I recognize that medical information which could be pertinent to the oral health care I receive in the course of the Examination may be communicated to the CDCA, CDCA examiners, the staff and clinicians of the dental school which is the location of the Examination, and other medical professionals when deemed medically necessary or when necessary for the administration of the Examination. I authorize this disclosure. This authorization specifically includes the disclosure of radiographs (X-rays), and information about my current medical and dental condition and my prior medical and dental condition.

Medical Condition and Medications

I have fully disclosed my current medical conditions and medical history to the best of my knowledge. I understand that if I am taking medications (especially those indicated on the Medical History in question 10) that are associated with certain chronic conditions, I may not be accepted as a patient for the Examination. I have fully disclosed all medications that I am currently taking. I have been informed that patients who are taking bisphosphonate medications may be at risk of osteonecrosis of the jaw after dental treatment or as a result of dental infections.

Candidate Sequential:____

PLACE ID LABEL HERE

Test Site:____

Consent to X-Rays and Photographs

I consent to the taking of appropriate radiographs (X-rays) and the examination of my teeth and gums. I also consent to having CDCA examiners or the staff and clinicians of the dental school take photographs of my teeth and gums for use in future CDCA examinations, provided that my name is not in any way associated with the photographs or X-rays.

Patient Consent, Disclosure, and Assumption of Responsibility

Anesthesia

I understand that as part of the dental hygiene procedure(s), it may be necessary to administer local anesthetics and I consent to the use of such anesthetics by the Candidate or dental professional selected and approved by the school where the examination is taking place.

Agreement

I release the CDCA, participating dental hygiene schools, and their employees and/or agents from any and all responsibility or liability of any nature whatsoever for their acts, any acts of the Candidate (including negligence), and the acts of any school employee (including any persons acting for or behalf of the school) which occur during the course of this Examination, and any damages or injuries I may suffer as a result of my participation in the Examination. With full knowledge of all the risks described above, I hereby expressly assume all risks as described or which can be inferred from the statements in this document. I further agree that neither the CDCA nor the participating dental or dental hygiene schools nor their employees or agents are responsible to provide any medical evaluation treatment, counseling, follow-up care, or any compensation for any condition or occurrence arising out of any act or omission of the Candidate and I hereby indemnify and agree to hold them harmless from any such claims and expenses, including attorney fees.

I verify that I am not a dentist or dental hygienist (licensed or unlicensed), a dental student in the 3rd, 4th, or final year of dental school, or a dental hygiene student in the final year of school.

By my signature below, I verify that I have read and fully understood the above information, and I agree to the terms of this agreement.

Patient's Name (Print): _____ Date: _____

Address: _____

Sex (Circle): M F Age: _____ Telephone #:_____ Email Address_____

Patient's Signature: _____

CANDIDATE INITIALS: _____ DATE INITIALED: _____ CANDIDATE SIGNATURE: _____

(Added at end of exam)