



DENTAL EXAMINATION (Required for all Dental Assisting applicants.)

_____ has applied for admission into the KDM Dental College International Inc. Dental Assisting Program. During the clinical courses, specific dental services can be provided by classmates once they have demonstrated competency at the pre-clinical level on mannequins. These can include dental radiographs (available to the students following evaluation), oral prophylaxis, topical fluoride application, desensitizing, pit and fissure sealants and PSR.

We understand that this individual is a patient in your dental practice. Please complete this form to assist with program admission. Thank you for your cooperation.

1. Contraindications for the above named services: _____ Yes _____ No

In order for these procedures to be performed at the school they must be prescribed by a dentist. Indicate the procedures that you are prescribing below.

Procedure	Location	Yes	No
Radiographs	Periapicals(s)		
	Bitewings		
	Full Mouth Series		
	Panoramic Film		
Coronal Polishing	Selective		
	Full Mouth		
Topical Fluoride Application			
Pit and Fissure Sealants	If yes indicate where:		
Desensitization	If yes indicate where:		
Periodontal Screening and Recording/Probing			

2. Date of most recent dental examination: _____

Comments: _____

3. Requires premedication as a preventive procedure for a heart murmur or other condition _____ Yes _____ No

If yes, give the name of procedures requiring pre-medication, reasons, drug name, dosage and duration: _____



Dental Examination (continued)

4. Date of most recent scaling: _____
Is further scaling required prior to prophylaxis? _____
Does the student have significant periodontal disease? _____

5. I certify that this information is true and correct to the best of my knowledge and that the student is in good oral health. I understand the recommended procedures will be performed by KDM Dental College by classmates during the Dental Assisting Program.

Dentist's Signature _____ Date: _____

A.D.A. License No: _____

Dentist's Name: _____

Address: _____

Telephone: _____

6. I authorize KDM Dental College International Inc. to collect information from my employers, dentist, and physician for the purpose of admission to and participation in the Dental Assisting Program.

Applicant's Signature

Date

Personal information contained in this Application Package is collected and will be used only for the administration of the Dental Assisting Program.



MEDICAL EXAMINATION (Required for all Dental Assisting applicants.)

Applicants for the Dental Assisting Program must be physically and mentally healthy having good vision and a high level manual dexterity. Dental Assistants must be able to function in a fast paced environment demonstrating critical thinking and problem solving skills.

To be completed by a physician:

_____ has applied for admission into the Dental Assisting Program. Your cooperation in completing this form is appreciated.

1. General Health: _____

2. Vision (corrective lenses permitted):
20/20 Near & Far _____ Full Color _____

3. Hearing Loss or disorders:
If yes, explain: _____

4. Presence of communicable disease: Yes _____ No _____
If yes, explain: _____

5. History of Hepatitis: Yes _____ No _____
If yes, state type, date, and present status.

6. Date patient received Hepatitis B Vaccine. **(Highly recommended for this program)**
Date: _____

7. Date patient received tetanus vaccine. **(Highly recommended for this program)**
Date: _____

8. Has patient received other vaccines such as Diptheria, Poliomyelitis, Rubella, Influenza, Measles, Mumps, Chicken Pox.
Date: _____ Yes _____ No _____

9. Has patient had a mantou test? **(Highly recommended for this program)**
Yes _____ No _____
Date: _____ Results: _____

10. Has patient ever had rheumatic fever or does this patient have a heart murmur? Yes _____ No _____
If yes, is prophylactic antibiotic coverage required?
Yes _____ No _____



Medical Examination Report

11. Any systemic or congenital conditions or diseases that may affect dental treatment or that clinical instructors must be aware of?

If yes, explain: Yes _____ No _____

12. Contraindications to dental treatment: Yes _____ No _____

If yes, please specify _____

13. HIV Status: (Currently not mandatory)
Positive _____ Negative _____ Not Known _____

Date tested: _____

14. Does this patient have any special needs that may need to be addressed to function successfully in a dental office environment?

Yes _____ No _____

15. In my opinion there is no physical/psychological contraindication to this patient entering a career in dental assisting.

I certify that this information is true and correct to the best of my knowledge.

Physician's Signature: _____ Date: _____

Physician's Name: _____

Address: _____

Telephone: _____

16. I authorize KDM Dental College International Inc. to collect information from my employers, dentist, and physician for the purpose of admission to and participation in the Dental Assisting Program.

Applicant's Signature

Date

Comments:

