# Student Demographic Sheet

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<tr>
<th>First Name</th>
<th>Last Name</th>
<th>DOB</th>
<th>Last 4 SSN</th>
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<th>Address</th>
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<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tr>
<th>Home/work telephone number</th>
<th>Cellular Number</th>
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Best number to reach you? ____________________________

E-Mail (if applicable) - this is a great way for us to communicate; e-mail addresses are not shared/sold

List any allergies that you feel we need to be aware of including food & drugs: ____________________________

*Examples: Latex, Penicillin, Peanuts*

List any medical conditions you have that you feel we need to be aware of: ____________________________

*Examples: Asthma, Epilepsy, Hepatitis ~ Please Highlight~*

Emergency contact: ____________________________ Phone #: ____________________________

(Relationship)

Do we have your permission to post pictures of you on our website & Facebook showing you in classroom activities? Yes or No (circle one) – Please sign below giving consent

Student Signature: ____________________________ Date: ____________________________
FINANCIAL & TUITION ARRANGEMENTS

Student Name: ___________________________________________ Class____________________

This tuition for the dental assisting course study offered by this institution is $2,900.00

The above tuition covers all cost for the cost. Dinner is not provided, however, several eating establishments are near our school.

This course will run eleven (11) consecutive weeks, two (2) nights a week, eight (8) classroom hours per week for a total of Eight (80) - classroom hours of instructions. Our classes are held on Tuesday & Thursdays [occasionally, we may need to modify our class night for special unforeseen reasons if this should occur, it will be discussed prior to the change. In addition, there is approximately sixty- (60) hours of home study plus a voluntary four (4) to (10) hours of “practical” on the job training for a total of approximately one hundred & fifty (150) course work hours.

The Tuition fee includes all the following

1. Textbook: “Modern Dental Assisting”, Torreres & Enrich, 10th addition- this book is available for check out
2. Textbook: (Syllabus) “Concepts in Dental Assisting”, Richard Erickson, DDS- this is yours to keep
3. Safety Glasses, pen, red/blue duel ended pencils, carry bag- these supplies are checked out and must be returned prior to graduation.
4. Use of all equipment & instrumentation with actual “hands on” training during the course of study
5. A certificate in dental assisting, dental assisting pin, and a letter recommendation outlining your training and experience will be awarded to all students who have attained a 75% or above grade average and your account is paid in full
6. X-Ray training in accordance with the state regulations in a dental offices
7. Training in all phases of general dentistry, including amalgam restorations, oral surgery, orthodontics, periodontics as well as pediatric dentistry. We do our best to schedule guess speakers who can’t wait to answer your questions. They are actively working in the dental field.
8. A certification in Adult CPR, is provided after course finals
9. OSHA & HIPPA training in the dental offices
10. Actual clinical experience & live patient practice
11. All training is done by a dental profession in an actual practicing dental office not a classroom

The tuition my be paid in full using one of the following arrangements:

1. $2,900.00 at the time of registration
   a. ($100.00 is a non-refundable deposit)
2. $1000.00 down payment (due at the time of registration), then $190.00 at the beginning of every week for ten (10) payments.
   a. ($100.00 is a non-refundable deposit)

Please fill out the following application, bring your form of payment arrangements to reserve your spot
Financial & Tuition Arrangements

Student Name: ____________________________________________ Class: ____________________________

I have selected the following payment plan for the dental assisting course:

_________________________ $2,900.00- Paid in full (enclosed)
    (includes $100.00 non-refundable deposit)

_________________________ $1,000.00 down payment (enclosed)
    (includes $100.00 non-refundable deposit)

Agreeing to pay the following payments of $190.00 per week for the next ten (10) weeks. Please note, in order to graduate you must have zero balance and all check out items must be returned.

Please complete the following to reserve a place in our next class:

( ) Payment in full (includes $100.00 non refundable deposit)        ( ) Master card or Visa ________________

( ) $1,000.00 down payment ($100.00 non refundable deposit)        ( ) Cash

( ) Check #: ____________________________        ( ) MYCAA

( ) Money order #: ____________________________

Credit card information- **We have to proof of identification ie. Drivers license to run the credit card (no exceptions)**

Name on card: ___________________________________________________________________________________

Credit card #: ___________________________________________________________________________________

Expiration date: ____________________________ CCV#: ____________________________

Billing address: __________________________________________________________________________________

City: ____________________________ State: ____________________________ zip code: ____________________________

Phone #: ____________________________ Last 4 digits of SS #: ____________________________

Print Name: ___________________________________________________________________________________

Student Signature: __________________________________________________________________ Date: ___________________________________________________________________

It is helpful to have the credit card for all payments.
Cancellations & Refunds

Students Name: _________________________________________________________________ Class: _________________________

1. A graduation certificate, letter of recommendation, and a dental assisting pin will only be awarded to those students attaining a 75% or above grade average (see student handbook for details). Those students whose grade average is below 75% will not receive a certificate but will be allowed to retake the entire course (if desired) at a reduced fee of $1,300.00 (minus a $100.00 non-refundable deposit).

2. A full refund will be made of all deposits or payments if cancellation is made three (3) calendar days before the start of the first class. (If you have already picked up your uniform- this must be turned into the office of Careers In Dentistry before a refund will be made (minus the $100.00 non-refundable deposit).

3. After the three (3) calendar days, refunds are based on a percentage of the course completed. The percentage is adjusted weekly. For example, if a student completes the first week of class, all but 10% will be refunded (minus the $100.00 non-refundable deposit).

   Before this is refunded all checked out items including your uniform must be returned to the office of Careers In Dentistry before a refund is issued.

   You will be required to sign a Cancellation & Refund document

We would love to hear how you found out about our course

(   ) Internet  (   ) Newspaper
(   ) Word of mouth  (   ) Facebook
(   ) Former student- Name: _________________________________________________________________________________
(   ) Other: __________________________________________________________________________________________________

Print Name: ___________________________________________________________________________________________________

Student signature: ___________________________________________________________ Date: _________________________
Student Confidentiality Statement

Student Name: __________________________________________ Class: ____________________

As a student in the dental assisting program of Careers In Dentistry, I understand that I will be working with medical and dental records of patients in the CID dental assisting clinic as well as other dental offices while doing my clinical rotations/shadowing. I further understand that medical and dental records are confidential and person documents, I understand we must abide by the HIPPA laws.

I agree NOT to discuss the contents of any patients medical or dental records except with the patient or instructor, and only when such discussion is relative to the patients care or learning experience. I understand that these are records of Careers IN Dentistry as well as other dental offices that I may visit while doing my clinical /shadowing rotations. I understand that I will not remove or make copies from the dental assisting program or any other dental office during clinical/shadowing rotations. I understand a violation of the confidentiality policy established by CID Dental Assisting program may be grounds for dismissal of the program.

I have read and understand the CID Dental Assistant clinics notice of Privacy Practices and agree to comply with the policies by the program in compliance with HIPPA regulations.

Please read carefully and sign below that you understand entirely this agreement

Print Name: ______________________________________________________________________________________

Student Signature: __________________________________________ Date: __________________

Faculty members signature: __________________________________________ Date: __________________

You will find a copy of this agreement in our student manual
Student Communicable Disease Agreement

Student Name: ___________________________________________________________________________ Class: ____________________________

As a student in the dental assistant program of Careers In Dentistry, I understand that I will be working with patients in the CID dental clinic and the office of Dr. Benjamin C. Timmerman as well as other dental offices while doing my clinical/shadowing rotations that may be afflicted with a communicable disease such as HIV, Hepatitis and other illnesses. I further understand that the medical status of these patients is considered confidential information.

I acknowledge that I have been informed of my risk of exposure to blood and bodily fluids and understand the potential for transmission of the blood borne disease during patient care interaction.

I agree to provide care to all patients assigned to me regardless of their health status. I understand that refusal to provide care to any patient without consent of the dental assistant department head may result in my dismissal from the dental assistant program.

Please read carefully and sign/date below that you understand this agreement.

Print Name: ____________________________________________________________________________

Student Signature: ____________________________ Date: ____________________________

Faculty Member Signature: ____________________________ Date: ____________________________

You will find a copy of this agreement in our student manual
GNPEC Student Disclosure Form

Name of school: Careers In Dentistry
Address of school: 436 Furys Ferry Road          Augusta, Georgia 30907

1. Enrollment Agreement & Catalog
I have read and received a copy of the enrollment agreement, or equivalent document, and the school catalog. I understand that the term and conditions of these documents are not subject to amendment or modification by oral agreements.

__________ Student’s Initials

2. School Outcomes
I have red and received a copy of the school’s self-reported, unaudited retention, graduation, and placements rates for the preceding year as well as the most recent Georgia licensure test results, if applicable, for the program I am entering.

__________ Student’s Initials

3. Employment
I understand that upon successful completion of my training program, this school will provide placement assistants, However, I understand that the school does not guarantee any graduate a job. I have not been guaranteed employment to earn a specific salary range upon graduation.

__________ Student’s Initials

4. Refund Policy
I have reviewed the refund policy provided in the catalog and am aware that the institution attests to the fact that the policy meets the Minimum Standards set forth by the Georgia Nonpublic Postsecondary Education Commission.

__________ Student’s Initials

5. Complaint procedure
I have reviewed the complaint procedure provided in the catalog and am aware that, after exhausting the institution’s procedure, I have the right to appeal the institution’s complaint determination to the Georgia Nonpublic Postsecondary Education Commission.

__________ Student’s Initials

6. Authorizations and Accreditation Status
I understand that the institution in which I am enrolling has been issued a Certificate of Authorization by the Georgia Nonpublic Postsecondary Education Commission. This status indicates that the institution has met the Minimum Standards established by Georgia code (20-250.6). Although authorized, I understand that this institution is not accredited by a U.S.-based accrediting association recognized by the United States Secretary of Education; therefore, I am not eligible for Federal Student Aid. Additionally, as the case with all postsecondary institutions, both accredited and unaccredited, there are no guarantee that my credits will transfer to another institution.

__________ Student’s Initials

Student’s Signature: ___________________________________________________________ Date: ________________________________

School Representative’s Signature: ________________________________________________ Date: ________________________________
Grievance Policy

Student Name: __________________________________________________________ Class: __________________________

We at Careers In Dentistry hope you have a good experience while going through our program. If at anytime you have any complaints or concerns we ask that you please write them down and place in our discussion box with or without your name on it. This box will be out for every class as well as the student handbook.

Dr. Timmerman or Jari will address the concerns and we will do our best to resolve any matter. You must do a written grievance complaint within two weeks of the incident. Please allow seven (7) days for a response, if you do not agree with the response you ninety-days (90) to appeal with the GNPEC.

If this doesn’t resolve the matter, then speak with the instructor personally before or after class. You may also call Dr. Timmerman at the number listed above. You also can contact Jari directly at 706-832-0829 or email Jari at Jad.careersindentistry@aol.com. Please do not let any situation build up and cause an issue. We are here to help you learn and be the best dental assistant you can be in your new career.

If neither method is helping then you may get in touch with the GNPEC- Georgia Nonpublic Postsecondary Education Commission by either calling them at (770) 414-3300 or at www.gnpec.georgia.gov or at the address listed below:

2082 East Exchange Place, Ste. 220
Tucker, Georgia 30084

We thank you again for being apart of our program and look forward to working with you.

Please sign below that you have read and understand the following policy.

Print Name: __________________________________________________________

Student Signature: __________________________________________ Date: ______________________
New Student Questionnaire

Student Name: ______________________________________________________ Date: ____________________________

Please give us in a few sentences a brief summary about yourself: ______________________________________________________

1. Are you currently employed? If yes, where? _________________________________________________________________
   Job title: ____________________________________________________________________________ Full time/ Part time?

2. What made you decide to want a career in the dental field? ____________________________________________________

3. What are your goals to achieve from our school? __________________________________________________________

4. What are your expectations of our faculty? ____________________________________________________________________

5. Do you feel as though you’re a team player and can adjust to change easily? _________________________________

6. Do you have any conflicts that would cause you to miss classes? If yes, list. __________________________________________________________________________

7. Do you expect to have any issues getting time off your job for your clinical interning/shadowing? ______

8. Do you have any anxiety of taking quizzes and/or test? __________________________

9. Do you have any dental experience? If yes, list experience:____________________________________________

10. Do you have any issues with needles, seeing blood? If yes, list:_________________________________________