Dental Foundation of Oregon – Tooth Taxi
Treatment Consent and Agreement Form

I, _____, as a legally responsible guardian of _____
(print parent/legal guardian name) (print child's name)

authorize and request the performance of dental services for my child. This treatment may consist of dental x-rays, diagnosis, topical fluoride application and other preventive measures as well as fillings, extractions, stainless steel crowns and preventive orthodontic (dental) procedures as recommended by the Tooth Taxi dentists. I understand that the Tooth Taxi dentists will use restorative treatment and behavior management that is reasonable and necessary, including local anesthetics and nitrous oxide as needed.

I consent that the dentist may administer medications to my child as appropriate and necessary based on treatment provided. Medications: acetaminophen or ibuprofen, per standard dose for age.

I understand there may be risks involved with dental treatment.

I consent and authorize the Dental Foundation of Oregon Tooth Taxi program to file and collect any insurance, private or Oregon Medicaid/OHP reimbursement for dental services performed. I also certify that I am the legal guardian for this child and have the authority to authorize treatment. I understand and agree to the conditions described above.

Parent/legal guardian name _____
(please print)

Relationship to child_____

Signature_____**Date**_____

After School Appointments: Tooth Taxi staff may be able to provide appointments after school. Are you able to provide transportation for your child for an after school appointment? ___Yes ___No. If yes please provide contact information.

Name: _____ Relationship: _____ phone#:_____

Photo Consent and Release (Optional)

I consent to the use of pictures, video or audio recordings of myself or my child for education, program promotion, including print, audio, video and web promotion. I also agree that any writing or other material in connection with the Tooth Taxi (including any correspondence from our family to The Dental Foundation of Oregon, Tooth Taxi) may be used in promotional materials.

Signature of parent/legal guardian_____Date_____

THIS FORM IS 2-PAGES

Authorization of Release of Protected Health Information

By signing this document, you are allowing the Dental Foundation of Oregon Tooth Taxi staff to give or receive from other health care providers or child agencies your child's health care records to provide the best care for your child. The records may be sent to another dentist, dental specialist or other health care provider that the Tooth Taxi staff recommends further treat your child. The information may also be shared with an agency that your child is affiliated with (such as school, Head Start, etc.) for record keeping purposes.

Patient's Name _____

I hereby authorize:

Dental Foundation of Oregon- Tooth Taxi
8699 SW Sun Place
Wilsonville OR 97070-2448

to receive from or release to the appropriate health care provider or agency, my child's records to facilitate his or her health care needs and/or treatments.

Name of parent/legal guardian_____
(please print)

Parent/legal guardian

signature_____**Date**_____

HIPAA
Acknowledgement of Receipt of Notice of Privacy Practices

I have recieved a copy of the Dental Foundation of Oregon's Tooth Taxi's Notice of Privacy Practices.

Parent/legal guardian

signature _____**Date**_____

THIS FORM IS 2-PAGES