South Lane Children's Dental Clinic

Treatment Consent and Agreement Form

1275 South River Rd. Cottage Grove OR 97424
(541)942-3383

I, _____, as a legally responsible guardian of _____
(print parent/legal guardian name) (print name of child)
authorize and request the performance of dental services for my child. I understand that the Dental Clinic dentists will use restorative treatment and behavior management that is reasonable and necessary, including local anesthetics and nitrous oxide as needed.

I consent that child may receive dental services provided by the Dental Clinic, and consent that their dentists and other agents and employees may furnish to the Dental Clinic employees and/or authorized organizations all information concerning the child's case history, dental examinations, written reports (and any accompanying photographs) with respect to the dental examination and the exam results. An authorized organization is one approved by the South Lane Children's Dental Coalition at the South Lane Children's Dental Clinic in Cottage Grove Oregon.

I consent and authorize the Dental Clinic program to file and collect any insurance, private or Oregon Medicaid/OHP reimbursement for dental services performed. I also certify that I understand and agree to the conditions described above.

I am consenting to let my child receive the following services:

Dental X-Rays	☐	☐
Fluoride Varnish Treatment	☐	☐
Dental Cleanings	☐	☐
Restorative Dental Treatment (including alloy fillings)	☐	☐
Endodontic Treatment(Root Canal)	☐	☐
Extractions	☐	☐
Use of Nitrous Oxide ("Laughing Gas")	☐	☐
Local Anesthetic (Numbing Agent)	☐	☐
Are you currently the legal guardian for this child?	☐	☐
Can you sign for medical treatment?	☐	☐
I understand the risks involved with dental treatment.	☐	☐

Parent/legal guardian name _____ (please print)

Relationship to child_____

Signature_____Date_____

I consent to have my child's photo used in grant reports, media print and informative content that pertains to South Lane Children's Dental Clinic.

Parent/legal guardian signature_____

I consent for my child to be provided transportation to the South Lane Children's Dental Clinic by a South Lane School District/Creswell/NorthDouglas School District Employee.

Parent/legal guardian signature_____

I Consent for South Lane Children's Dental Clinic to bill my child's insurance if available.

Parent/legal guardian signature_____

South Lane Children's Dental Clinic
1275 S. River Rd Cottage Grove OR 97424
North Douglas
(541)942-3383
School District

tient Name_____**Middle Int.**____ **Birth Date**_____
Parent/ Guardian Name_____
Address: Street _____
City _____State _____Zip_____
Phone Numbers: Home (___) _____ **Email:**_____
Cell (___) _____
Parents Work (___) _____ Employer Name _____
School Attending_____ **Grade**_____ **Age**_____ **Sex** (circle) ☐ ☐
Emergency Contact: Person to contact in case of emergency
Name _____
Relationship to patient _____ Phone (___)_____
Ethnicity: Which one of these groups would you say best represents the patient's race? (Optional) *White Hispanic Black or African American Asian American Indian Other*_____
Income: Which of these best represents your annual household income? (Circle One)
$0-$12,000 $12,001- $17,000 $17,001-$25,000 more than $25,000
Household Size: How many children less than 18 years of age live in your household?_____

Required Information **If your child currently has OHP we will make the request that Advantage is their provider and attempt to submit an insurance claim. If not covered you will NOT be responsible for the financial portion.**

Does your child get/have ☐ **OHP/Trillium/Advantage Insurance**
D. #_____**or SS#**_____
Free/ Reduced Lunch ☐_____

Reason for Visit: Check all that apply:

- ○ 1st Examination
- ○ Toothache
- ○ General Mouth Pain
- ○ Accident to Teeth
- ○ Bleeding Around Teeth
- ○ Routine Exam
- ○ Teeth Appearance
- ○ Couldn't get appointment anywhere else
- ○ Other_____

Patients Current Physician_____
Past or current Dentist_____

FOR X-RAYS ON FEMALES: Could this patient be pregnant? Yes ☐ **No** ☐

I understand this signature is good for 24 months from today's date:

Parent/Guardian signature_____**Date:**_____

(Turn Over Page 1 of 2)

Dental History	Yes	No		Please Explain
Is this the patient's first dental visit? If no, how long has it been since the patient last saw a dentist?	☐	☐		
Has the patient had any unpleasant experiences in a dental or medical office?	☐	☐		If yes, Please explain....
Does the patient brush daily?	☐	☐		If yes, how often?
Does the patient floss?	☐	☐		If yes, how often?
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-aid, fruit drink, Gatorade, sports drinks etc...)	☐	☐		How many does the patient drink per day?
Does the patient drink milk daily?	☐	☐		How many times per day?
Does the patient sleep with a bottle or use a sippy cup other than at meals?	☐	☐		

Medical History	Yes	No	Please Explain "Yes" Answers
Does the patient have a current medical condition?	☐	☐	
Is the patient taking and medications?	☐	☐	
Has the patient ever been hospitalized or had surgery?	☐	☐	
Does the patient have any allergies?	☐	☐	
Does the patient have allergies to drugs?	☐	☐	
Is the patient currently protected by immunization (shots) against DT, Polio, Measles, Mumps, and Rubella?	☐	☐	
Does the patient have and special needs that would require special arrangements for dental care?	☐	☐	

Has the patient had a history of or had difficulty with any of the following? Check all that apply

☐ Latex Allergy	☐ Anemia	☐ Diabetes	☐ Mono
☐ AIDS/HIV	☐ Asthma	☐ Fainting	☐ Mumps
☐ Epilepsy/seizures	☐ Bladder problems	☐ Hearing problems	☐ Rheumatic fever
☐ Chronic ear infections	☐ Cancer	☐ Hepatitis	☐ Tuberculosis
☐ Chronic eye infections	☐ Cerebral Palsy	☐ Kidney disease	☐ Sinus problems
☐ Sore throat	☐ Chicken Pox	☐ Liver disease	☐ Convulsions

- **Other**_____

Consent for Silver Diamine Fluoride with Fluoride Varnish Therapy to Arrest Decay

The use of silver diamine fluoride in dentistry has been well documented for its safe and successful ability to control tooth decay. Its application is a conservative approach for the treatment of active decay.

The procedure:

- **The teeth are dried with air.**
- **Application of 38% Silver Diamine Fluoride (FDA approved) to appropriate teeth with visible cavities in very small amounts using a micro brush**
- **Application of 5% Sodium Fluoride varnish (FDA approved) used to seal Silver Diamine Fluoride into the treated tooth and to arrest the decay in the tooth.**

Possible Side Effects:

- A cavity in the presence of Silver Diamine Fluoride will turn that part of the tooth dark. This is an indication that the decay in the tooth is arresting.
- If Silver Diamine Fluoride comes in contact with skin and/or gums, temporary discoloration will occur.
- Silver Diamine Fluoride placed on demineralized enamel may cause discoloration.
- Temporary irritation of the gums that will subside quickly

If you notice other effects not listed above please contact us.

Treatment of tooth decay with Silver Diamine Fluoride does not necessarily prevent the need to place a regular filling in the affected tooth in the future in order to restore function and esthetics.

Do not eat for one hour and do NOT brush your teeth for 24 hours after treatment.

The above treatment technique has been explained to me to my satisfaction and I understand it fully. I have read this form, and understand the treatment. I understand I may refuse treatment.

I understand this consent will be good for 24 months from date of signature.

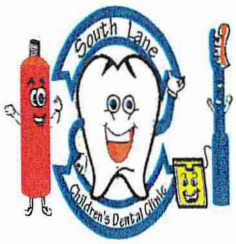
I give my consent for providers at South Lane Children's Dental Clinic to administer Silver Diamine Fluoride on:

Patient Name:_____

Printed Name of Parent/ Legal Guardian:_____

Signature of Parent/Legal Guardian:_____Date(Good for 24 mo. From this date):_____

South Lane Children's Dental Clinic (541)942-3383



Patient HIPAA Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996(HIPPA).
I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment(including direct or indirect treatment by other health care providers involved in my treatment)
- Obtaining payment from third party payers(my insurance company)
- The day-to-day health care operations of South Lane Children's Dental Clinic

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you agree, you are bound to comply with this restriction.
I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Date:_____

Print Patient Name:_____

Signature of Guardian:_____

Relationship to Patient:_____