

# Dental Foundation of Oregon – Tooth Tax 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 child. This treatment may consist of dental x-rays, diagnosis, topical fluoride application and other preventive measures as well as restorations, extractions and preventive orthodontic (dental) procedures as recommended by the Tooth Tax dentists. I understand that the Tooth Tax 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. If an infection is present the dentist may dispense antibiotic Amoxicillin or Clindamycin prior to dental treatment.

I consent that child may receive dental services provided by the Tooth Tax, and consent that their dentists and other agents and employees may furnish to Tooth Tax 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 Tooth Tax program and the Dental Foundation of Oregon.

I consent and authorize the Dental Foundation of Oregon Tooth Tax 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.

Are you currently the legal guardian for this child? YES NO  
Can you sign for medical treatment? YES NO  
I have been informed of the risks involved with dental treatment YES NO

Parent/legal guardian name \_\_\_\_\_  
(please print)

Relationship to child \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

After School Appointments: Tooth Tax 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 Tax (including any correspondence from our family to The Dental Foundation of Oregon, Tooth Tax) may be used in promotional materials.

Signature of parent/legal guardian \_\_\_\_\_ Date \_\_\_\_\_