OREGON HEALTH & SCIENCE UNIVERSITY

SmileKeepers DENTAL

UNIVERSITY OF THE PACIFIC
Arthur A. Dugoni School of Dentistry

Consent for participation in tele-dentistry pilot program

Child's name:______________________________ M_____ F_____ Other_____

Child's home address ______________________________

City ______________________________ State__________ Zip code__________

Child's date of birth (mm/dd/yy) ______________

For data purposes, please complete the following sections:

Child's ethnic background:

☐ White/non-Hispanic ☐ Hispanic/Latin ☐ Native American/Alaskan Eskimo ☐ African-American

☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Other ☐ (please describe)______________

Dental Insurance carrier : ☐ OHP/Medicaid ☐ Private **ID#** ______________

☐ I don't know ☐ Please check here if student does not have dental insurance

If you are interested in getting your child enrolled in an insurance plan, contact the Oregon Health Plan at 1-800-359-9517

PURPOSE: The purpose of this form is to obtain consent for the participation in a system of dental care called "tele-dentistry". This system offers limited dental treatment in a clinic location rather than in a dental office . Delivery of care through this system is a part of a pilot project run by Capitol Dental Care (CDC), a dental health plan working in conjunction with Oregon Health Sciences University's School of Dentistry and the University of the Pacific's School of Dentistry. Services provided under this system include tele-dentistry consultation and standard dental hygiene and dental office procedures.

PLEASE CHECK YES OR NO

☐ **YES** — **I WANT** my child to be included in this pilot program and receive preventive and diagnostic services

☐ **NO** — **I DO NOT** want my child to participate in this program

IF "YES", Please complete the back of this page.

By signing below, I am stating that this form has been filled out to the best of my knowledge. I am also agreeing to the following statements.

- I have read the "Tele-dentistry Facts and Information" page
- I have been given a copy of the Notice of Privacy Practices.
- Information may be sent to my child's insurance company (if applicable) or to a third party payer to request reimburse-
- The results may be shared with my dental provider.
- This consent remains in effect for 24 months.

Parent/Guardian Signature: ______________________________ **Date:** ______________

If you checked "YES", please complete the back side of this page.

Revised 9/16

State law requires a basic medical history for each child receiving service. Please complete the following.

My child has:

- ☐ Heart murmur or has had heart surgery
- ☐ Asthma/hay fever
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Epilepsy/seizures
- ☐ Bleeding problems/bruising
- ☐ Cancer
- ☐ Skin problems
- ☐ Other (please describe): ____________________

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☐ Behavioral Considerations (please describe): ____________

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My Child is taking (list medications):

My Child is allergic to:

Parent/Guardian Name:____________________

Daytime Phone Number:

Dental History:

In the past, what have been barriers to the child receiving dental care?

- ☐ **We have no current barriers to care**
- ☐ **Transportation Issues**
- ☐ **Cost of care/no insurance coverage**
- ☐ **Time Commitment/length of appointment time**
- ☐ **Anxiety/Fear of the dentist**
- ☐ **No knowledge of local providers**
- ☐ **I can't find a dentist who will treat my child**
- ☐ **It takes too long to get my child an appointment**
- ☐ **I can't take time off of work for the appointment**
- ☐ **Other (please describe)**____________________

When was your child's last dental exam?

- ☐ **Within 6-12 months (1)**
- ☐ **Within 13-24 months (2)**
- ☐ **2+ yars ago (3)**
- ☐ **Never**
- ☐ **I don't know**

Has your child had x-rays before? ☐ **Yes** ☐ **No**

If yes, approximately when? ____________________

Dentist name/office name and location if known____________________

Is your child currently complaining of pain in their mouth/pain when eating/pain causing them to wake at night?

☐ **Yes** ☐ **No**

Dental Professional License Category: Expanded Practice Dental Hygienist (EPDH)

The dental care provider that is providing care on behalf of my child has discussed with me the information above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read and agreed to allow my child to participate in this study to demonstrate the effectiveness of a new system of oral health care involving tele-dentistry consultations. I agree to have records of my child , including, electronic versions of x-rays, photographs, charting of conditions, and health and other history information, collected from him or her and shared and used as described in this consent form and in the "Notice of Privacy Practices" which I have received. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment I have requested and authorized on behalf of my child.