TOOTH TAXI

RETURN TO SCHOOL BY: ____Sept 12, 2018_

Dental Foundation of Oregon
Tooth Taxi Form Checklist

For your child to receive treatment in the Dental Foundation of Oregon's Tooth Taxi the following forms need to be completed and returned to (name) _____**Pam Hayes**_____ **by (date)** _____**Sept 12, 2018**_____.

FORM NAME – Return to school	**Check if attached**
Treatment Consent-med-Photo Consent	
Patient Information (dental & medical history)	
Acknowledgement of Receipt of Privacy Practices & Authorization of Release of Protected Health Information	

The following forms that you received should be kept for your information; **they are not returned to the school**:

FORM NAME – Parent/Legal Guardian keeps
Notice of Health Information Disclosure and Access
Patient Rights and Information, Patient Responsibilities, Patient Risks

PLEASE RETURN THIS CHECKLIST WITH REQUIRED FORMS.

Dental Foundation of Oregon – Tooth Taxi
Patient Information Form

THIS FORM IS 2-PAGES

Please fill out this form **completely**. If you have questions, please contact your school co-coordinator.

Patient's Legal Name _____ **Birth Date** (mm/dd/yyyy) _____

Patient Nickname_____ **Parent or Legal Guardian Name** _____

School Attending _____ **Grade** _____ **Age** _____ **Sex** (circle) M F

Home Address _____
Street/ P.O. Box City State Zip

Phone Numbers: Home (____) _____ Work (____) _____

Cell (____) _____

Emergency Contact: Person to contact in case of an emergency

Name _____ Relation to patient _____ Phone (____) _____

Ethnicity: Which one of these groups would you say best represents the patient's race? (circle one)

White *Hispanic* *Black or African American* *Asian* *American Indian* *Other*_____

Income: Which of these best represents your annual household income? (circle one)

Less than $10,000 *$10,000-20,000* *$20,000-30,000* *More than $30,000*

Household Size: How many children less than 21 years of age live in your household? _____

Dental History	Yes	No	Please explain answers
Is this the patient's first dental visit? If no, how long has it been since the patient last saw a dentist?			
Does the patient have to travel more than 60 miles for dental appointments?			
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, sport drinks)?			How many does the patient drink per day?
Does the patient drink milk daily?			How many times per day?
Has dental pain caused you or your child to miss school and/or work in the past year?			If "yes", circle – school work both How many times?
Has the patient visited the ER hospital for dental pain in the last year?			How many times?

Reason for Visit: Check any that apply (√)

☐ First examination	☐ Accident to teeth	☐ Routine exam	☐ Other (specify)
☐ Toothache	☐ Bleeding around teeth	☐ Couldn't afford dental care	_____
☐ Mouth pain/face swelling	☐ Teeth Appearance	☐ Couldn't get appointment anywhere else	

THIS FORM IS 2-PAGES

Medical History

THIS FORM IS 2-PAGES

Patient's Current Physician _____ **Past or Current Dentist** _____

Medical History	Yes	No	Please Explain "yes" Answers
Does the patient have a current medical condition?			
Has the patient been diagnosed with autism?			
Is the patient taking any medications?			
Has the patient ever been hospitalized or had surgery?			
Does the patient have any allergies?			
Does the patient have any allergies to drugs?			
Is the patient currently protected by immunization (shots) against DPT (diphtheria, whooping cough, tetanus) polio, measles, mumps, and German Measles (rubella)?			
Does the patient smoke or use any type of tobacco products?			
Does the patient have any special needs that would require special arrangements for dental care?			

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

☐ Latex allergy	☐ Anemia	☐ Diabetes	☐ Mono
☐ AIDS / HIV	☐ Asthma	☐ Fainting	☐ Mumps
☐ Epilepsy/ seizures	☐ Bladder problems	☐ Hearing problems	☐ Rheumatic fever
☐ Excessive bleeding	☐ Birth defects	☐ Heart problems	☐ Stomach/ intestinal disorders
☐ Chronic ear infections	☐ Cancer	☐ Hepatitis	☐ Tuberculosis
☐ Chronic eye infections	☐ Cerebral Palsy	☐ Kidney disease	☐ Other _____
☐ Sinus problems	☐ Chicken pox	☐ Liver disease	**For x-ray purposes:**
☐ Sore throats	☐ Convulsions	☐ Measles	☐ **Could the patient be pregnant?**

Please explain "yes" answers: _____

Behavioral Issues	Please Explain "yes" answers
Anything about your child's behavior that we should know to help us provide dental care? ___Yes ___No	

Insurance: Do you have OHP dental coverage? ___Yes ___ No. ID# _____

CIRCLE your **OHP** Dental Plan and provide a copy of the letter that gives ID#, CCO & dental assignment:

Access Advantage Capitol Care Oregon Family Dental Managed Care ODS Willamette

Is your child covered with The Children's Program? ___Yes ___No ID# _____ (include copy of enrollment letter with ID#)

Do you have PRIVATE dental insurance? ___Yes ___No If yes, please complete the following and provide a copy of dental insurance card.

Dental Ins.Co. name: _____ Ins Co. address _____

Subscriber Name: _____ Subscriber Date of Birth: _____

ID# _____ Employer Name: _____ Group #: _____

Parent/ Legal Guardian signature _____ Date _____

THIS FORM IS 2-PAGES

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 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 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. 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 Taxi, and consent that their dentists and other agents and employees may furnish to Tooth Taxi 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 Taxi program and the Dental Foundation of Oregon.

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 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 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#:_____

TOOTH TAXI

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 _____

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
PO Box 2448
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_____

If there are providers or agencies that you do NOT want your child's records released to or received from please list here:

_____ _____

HIPAA
Acknowledgement of Receipt of Notice of Privacy Practices

*You May Refuse to Sign this Acknowledgment

Patient Name_____

I,_____
(parent/legal guardian name)

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

Parent/legal guardian signature
_____Date_____

For Office Use only: *We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because: __Individual refused to sign, __Communications barriers prohibited obtaining the acknowledgment, ___ An emergency situation prevented us from obtaining acknowledgment, __Other (Please Specify)

Dental Foundation of Oregon – Tooth Taxi

Patient Rights and Information

Each patient shall have the right to:

1. Be treated with respect and dignity
2. Treatment which is free of discrimination on the basis of race, color, religion, disability, or sexual orientation
3. Safe and efficient treatment
4. Treatment that meets the standard of care of the profession
5. Voice their personal feelings via verbal or written means
6. Information concerning their diagnosis, and planned treatment for their dental needs
7. Obtain information as to any relationships this facility has with other professional individuals or medical facilities, in so far as their care is concerned
8. Expect confidentiality in communications and records pertaining to their dental treatments
9. The information necessary to give informed consent to treatment

Patient Responsibilities

Each patient /parent/legal guardian shall be responsible for the following:

1. Completing and returning to the school permission slip and all required consent forms for child to receive treatment
2. Providing accurate and complete information for use in notification of dental needs and appointments
3. Keeping appointments and notifying Tooth Taxi staff if unable to do so
4. Asking questions when he or she does not understand something
5. Being respectful and considerate of all staff and other patients being treated by the Dental Foundation of Oregon's Tooth Taxi
6. For their own actions, should they refuse treatment or for not following instructions given to them by the dental staff
7. To provide responsible transportation and assistance if needed
8. To follow all Tooth Taxi policies and procedures

Patient Risks

The risks of dental procedures are usually minimal. Risks may include reaction to anesthesia, bleeding, and infection. The x-ray system that the Tooth Taxi uses minimizes radiation exposure compared to conventional x-rays. Producing digital images significantly reduces radiation exposure. If there are additional potential risks, the treating dentist will contact the parent/legal guardian and/or patient. If you have further questions regarding any potential risks, please contact the Tooth Taxi prior to your child's visit.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 4, 2008 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by law. In addition, we may make the changes in our privacy practices and the new terms of our Notices effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment:
We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment:
We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations:
We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization:

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family And Friends:
We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care:
We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or adverse outcome. If you are present, then prior to use or disclosures of your health information, we will provide you with any opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays or other similar forms of health information.

Marketing Health-Related Services:
We will not use your health information for marketing communications without your written authorization.

Required By Law:
We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others, as otherwise required by law.

National Security:
We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders:
We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address listed at the end of this Notice. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting:
You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities over the course of the last six (6) years, but not before September 4, 2008, as that is the date the Tooth Taxi commenced operations. If you request a disclosure accounting more than once in a twelve (12) month period, we may charge you a reasonable fee for responding to these additional requests.

Restriction:
You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication:
You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment:
You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice:
If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may contact us with your concerns using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

This contact is only regarding privacy practices. For Tooth Taxi questions please contact your school coordinator.

Contact Officer: Nick Gross

Telephone: 503-952-5033

E-Mail: nick.gross@modahealth.com

Address: 601 SW Second Avenue
Portland, OR 97204