SCHOOL OF DENTISTRY
UNIVERSITY of WASHINGTON

Care Agreement

This form contains facts you should know about your dental care at UW School of Dentistry (UW SOD). If there is any part of this form that is unclear you can ask questions about it. Your signature is required at the end of this form acknowledging that you have read this form (or had it read to you), have been offered a copy of the Patient Rights and Responsibilities brochure and agree to receive dental care from us and to the terms of this agreement.

UW School of Dentistry includes:

Pre-DoctoralStudent Clinic
Dental Urgent Care
UW Dentists Faculty Practice
Advanced General Dentistry
Oral Medicine

Dental Education in Care of Persons with Disabilities
The Center for Pediatric Dentistry
Dental Fears & Research Clinic

Oral Maxillofacial Surgery
Endodontic Clinic
Periodontic Clinic
Prosthodontic Clinic
Orthodontics Clinic

Your dental care team consists of dentists, dentists in advanced training programs, dental students, dental assistants, dental hygienists, and other health care professionals. They will work together to diagnose and treat you. Photographs and other images of you may be used to keep a record of your care and treatment. These images may become part of your dental record.

Signature

By providing my email address to the UW School of Dentistry (UW SOD), I am authorizing the UW SOD to communicate via the email address provided regarding my/my child's care, appointments, special promotions and oral health information. I understand that UW SOD providers and staff will use reasonable means to protect the security and confidentiality of email information sent and received. I understand that because email is not secure, there are associated risks that may affect the privacy of my personal health care information when using email to communicate. I understand that if I no longer wish to have my email address on file, I must give verbal notice to any of the front desk staff within the UW SOD and the information will be removed and my request notated on my account.

By signing below, I agree that I have have read this document and agree to receive healthcare from UW School of Dentistry.

SIGNATURE (PATIENT OR AUTHORIZED REPRESENTATIVE)	PRINT NAME	DATE

IF SIGNED BY PERSON OTHER THAN PATIENT, CHECK RELATION TO PATIENT:

- ☐ 1. Guardian
- ☐ 2. Durable Healthcare Power of Attorney
- ☐ 3. Spouse/Registered Domestic Partner
- ☐ 4. Adult Child(ren)
- ☐ 5. Parent(s)
- ☐ 6. Adult Brother(s)/Sister(s)

FOR MINOR PATIENTS:

- ☐ 1. Guardian/Legal Custodian
- ☐ 2. Court-authorized person for child in out-of-home placement
- ☐ 3. Parent(s)
- ☐ 4. Holder of signed authorization from parent(s)
- ☐ 5. Adult representing self to be a relative responsible for the minor's health