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To whom it may concern,

Dental Care NSW would like to inform staff and parents about a potential visit for a Mobile Dental Program which is funded under Medicare's Government Child Dental Benefits Scheme.

Free dental care is provided to students between the ages of 2 and 18 years who are covered under the CDBS through Medicare. We can check and verify Medicare eligibility and parents will be notified of the child's status. Any child eligible under the Child dental benefits schedule will be granted $1158 over two years in benefits to cover the costs of dental treatments.

Our main aim at Dental Care NSW is to educate and promote quality oral health education through activities and PowerPoints. We also provide the treatment needed to ensure optimal oral health. These treatments include dental examinations to locate dental decay at an early age, cleans, fluoride application and fissure sealants (protective coating) to decrease future risk of decay. The parents will be provided with a letter of all treatment that was completed and a referral for any major treatments which need to be done. For further treatment, we have a clinic situated in Harris Park under the banner Pain Free Dentistry whereby it has been established for over 25 years.

We provide this for the children through our quality mobile dental services as we understand life can be busy and responsibilities are endless. Therefore, our skilled team of Dentists and Oral health therapists come to you through our fully equipped portable dental equipment ready to provide services to fulfil all needs of students.

Dental appointments may be frightening for children, that's why our trained staff specialises in creating a relaxing environment to help children in our care to get through the treatment and enjoy themselves and the experience. By encouraging your children to attend frequent check-ups from a young age, we hope to provide early intervention and crucial care. It is commonly acknowledged that teaching children to care for their teeth at an early age boosts their chances of having excellent oral hygiene as adults. Our program includes 6-month follow ups and recalls to monitor any early signs of dental diseases. We at Dental Care NSW are looking forward to meeting you in the near future.

Thank you

Kind regards,

Dental Care NSW Team

Student(s) details

Childcare/school: _____

Home Address: _____

Postcode: _____

Do you have a dental health fund? Yes/No

Name of Fund: _____ Membership Number: _____/___ Exp:_____

Child (1) EXACT name on Medicare: _____

Grade: _____Class: _____Age: _____

D.O.B____/____/_____ Gender: _____

Child's Medicare Card Number: _____ Reference No: __ Expiry: ____/_____/____

Does the child have any medical conditions/allergies? _____

Does your child take any medications? _____

Child (2) EXACT name on Medicare: _____

Grade: _____Class: _____Age: _____

D.O.B____/____/_____ Gender: _____

Child's Medicare Card Number: _____ Reference No: __ Expiry: ____/_____/____

Does the child have any medical conditions/allergies? _____

Does your child take any medications? _____

Child (3) EXACT name on Medicare: _____

Grade: _____Class: _____Age: _____

D.O.B____/____/_____ Gender: _____

Child's Medicare Card Number: _____ Reference No: __ Expiry: ____/_____/____

Does the child have any medical conditions/allergies? _____

Does your child take any medications? _____

Child (4) EXACT name on Medicare: _____

Grade: _____Class: _____Age: _____

D.O.B____/____/_____ Gender: _____

Child's Medicare Card Number: _____ Reference No: __ Expiry: ____/_____/____

Does the child have any medical conditions/allergies? _____

Does your child take any medications? _____

Child (5) EXACT name on Medicare: _____

Grade: _____Class: _____Age: _____

D.O.B____/____/_____ Gender: _____

Child's Medicare Card Number: _____ Reference No: __ Expiry: ____/_____/____

Does the child have any medical conditions/allergies? _____

Does your child take any medications? _____

<u>Your details – Parent or legal guardian</u>

Name (In Full): _____

Email Address: _____

Home: _____ Mobile_____

Treatment consent

Please tick if you agree to the following:

☐ To conduct a Medicare eligibility check in order to assess if your child is eligible for free treatment under the Child Dental Benefit Scheme.

☐ If eligible please provide free oral examination/scale/clean/fluoride, provide fissure sealants/temporary fillings/permanent sealing/x-rays.

If not eligible, please select option 1 or 2:
Please Note: Our team will contact you to arrange payment prior to the service. If payment is not made prior, your child cannot be seen.

☐ **Option 1:** Please provide oral examination/scale/clean/fluoride for $120. Parent/guardian will be contacted if additional treatment if necessary.

☐ **Option 2**: Please provide oral examination/scale/clean/fluoride/up to 4 x fissure sealants for $190.

☐ Do you give consent for photos/ X rays to be used for case presentations/ advertising without revealing your child's identity? Please tick if yes.

Should any major/additional treatment be necessary, parents/guardians will be informed and referred to our dental clinic.

Signed: _____ Date: _____/_____/_____

PLEASE NOTE:

If more than one child in the family is participating in the Dental health program, full names must be added to the bottom of the next page (Medicare CDBS bulk billing consent form) with their Medicare Reference Number next to their name. If any participating child has a separate/different Medicare card, a separate form must be filled.

Australian Government
Department of Health

CHILD DENTAL BENEFITS SCHEDULE
BULK BILLING PATIENT CONSENT FORM

I, the patient / legal guardian, certify that I have been informed:

- of the treatment that has been or will be provided from this date under the Child Dental Benefits Schedule*;*
- of the likely cost of this treatment; and
- that I will be bulk billed for services under the Child Dental Benefits Schedule and I will not pay out-of-pocket costs for these services, subject to sufficient funds being available under the benefit cap.

I understand that I / the patient will only have access to dental benefits of up to the benefit cap.

I understand that benefits for some services may have restrictions and that Child Dental Benefits Schedule covers a limited range of services. I understand I will need to personally meet the costs of any services not covered by the Child Dental Benefits Schedule.

I understand that the cost of services will reduce the available benefit cap and that I will need to personally meet the costs of any additional services once benefits are exhausted.

_____
Patient's Medicare number

_____
Patient / legal guardian signature

_____
Patient's full name

_____
Full name of person signing
(if not the patient)

_____
Date

This form is valid up to 31 December of the calendar year for which it is signed.