www.dmmsg.com.au info@dmmsg.com.au 02 8631 2415

CHILD DENTAL BENEFITS SCHEDULE

THE CHILD DENTAL BENEFITS SCHEDULE (CDBS) PROVIDES BASIC DENTAL SERVICES TO CHILDREN AGED BETWEEN 2 AND 17 YEARS.

ELIGIBILITY BASICS

- AGED BETWEEN 2 AND 17 YEARS AT TIME OF VISIT
- GETTING CERTAIN GOVERNMENT BENEFITS SUCH AS FAMILY TAX BENEFIT PART A FOR AT LEAST PART OF THE CALENDAR YEAR
- ELIGIBLE FOR MEDICARE

DMMSG
DENTAL MEDICAL MOBILE SERVICES GROUP

OUR PROGRAM INVOLVES:

- DENTAL EDUCATION ABOUT THE IMPORTANCE OF ORAL HYGIENE , TOOTH BRUSHING AND DIET HABITS
- COMPREHENSIVE ORAL EXAMINATION
- SCALE, POLISH AND CLEAN
- TOPICAL APPLICATION OF TOOTH MOUSSE (DECAY PREVENTION)
- OUR FRIENDLY STAFF AIM TO CREATE A COMFORTABLE, RELAXING AND FUN ATMOSPHERE FOR YOUR CHILDREN

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.

Child full name : _____

Child date of birth: _____

1 Child Medicare card number : _____

2 Child's individual reference number: _____

3 Expiry Date : _____

School/preschool name : _____

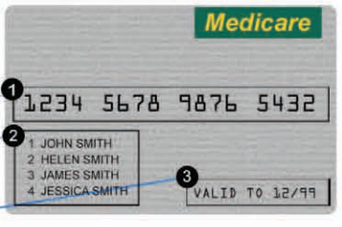
Class _____

Patient / legal guardian signature : _____

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

Guardian Contact Number : _____

Date : _____



When did your child last visit a dentist ? _____

Please provide details or discuss them with your dentist. Information about your medical history is for your dentist's use only.

Past/Current medical conditions		
Are you receiving any medical treatment at present?	Y / N	Details
Have you had any serious or long standing illness?	Y / N	Details
Have you ever been hospitalised?	Y / N	Details

Please indicate if you have EVER had any of the following:

Any heart complaint/treatment	Y / N	Any nervous system disorder	Y / N
Rheumatic fever or heart valve surgery	Y / N	Asthma/bronchitis/lung conditions	Y / N
High or low blood pressure	Y / N	Radiation therapy / chemotherapy	Y / N
Blood disorders / bleeding disorders	Y / N	Thyroid disease	Y / N
Epilepsy	Y / N	Hepatitis, jaundice or liver disease	Y / N
Diabetes	Y / N	Treatment for any form of cancer	Y / N
Familial diseases	Y / N	Transplanted organ or bone marrow	Y / N
Infectious disease (measles/chicken pox), especially in the last three weeks	Y / N	Kidney conditions	Y / N
Tuberculosis	Y / N	Other	Y / N
Details if yes to any of the above:			

Are your child's immunisations up to date?	Y / N	Current medications	
Allergies (e.g. latex, penicillin, etc):			

[ ] If eligible, please provide oral examination/clean/scale/fissure seals if required.

I agree that the above is a true and accurate record. Should you wish to discuss any relevant matters with your dentist prior to commencement of any dental treatments please call us on **02 8631 2415**

Signature : _____

Date: ___/___/____

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