oz smile
Mobile Dental Clinics

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OZ SMILE MOBILE DENTAL CLINIC – DENTAL CHECK-UPS AT SCHOOL

CHILD PROFORMA AND DENTAL HISTORY

Please complete all the details about your child and return this form to your school office. If your child is eligible for CDBS, this dental service will be bulk billed through Medicare and will not be charged directly to the patient.

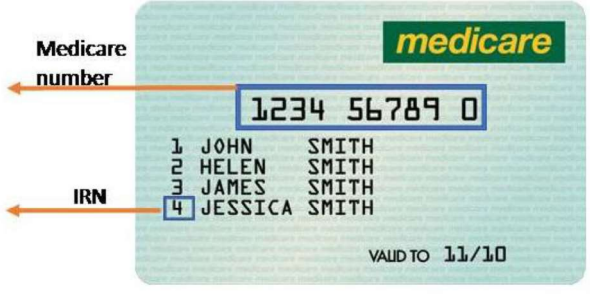
DETAILS OF YOUR CHILD:

First Name:	Middle Name:
Last Name(s):	Date of birth:
Home Address:	Gender:
	Phone (Home):
Parent Email:	Parent Mobile:
Emergency Contact Person:	Emergency contact Phone:
School Name:	Year and class:

MEDICAL AND DENTAL HISTORY (please circle)

Is your child allergic to any medicines or food? If YES, please give details:	**YES / NO**
Does your child have any medical condition(s)? If YES, please give details:	**YES / NO**
Is your child receiving treatment from another dentist? Has your child been to dentist in last six months? Dentist Name& Address:	**YES / NO** **YES / NO**

MEDICARE DETAILS (Please write clearly):

MEDICARE NUMBER :	
INDIVIDUAL REFERENCE NUMBER (IRN) of your child:	

Please turn over for consent and signature

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.