⚠ **For your child to be seen for their 2 visits this calendar year, this form must be completed correctly.**

1. Patient Details

First Name

Surname:

Date of Birth D D M M Y Y Y Y

Gender (please tick) ◯ Male ◯ Female ◯ Other

Class/Grade

2. Parent, Guardian OR Emergency Contact Details

Name

Phone

Address

Postcode

Email Address

3. Medical Conditions

Please tick if your child had/has any of the following medical conditions (if yes, please supply further information):

- ◯ ADHD
- ◯ Artificial Heart Valve
- ◯ Asthma
- ◯ Autism
- ◯ Bleeding Disorder
- ◯ Chronic Conditions
- ◯ Diabetes
- ◯ Epilepsy
- ◯ Hepatitis A, B or C
- ◯ Heart Conditions
- ◯ High/Low Blood Pressure
- ◯ Infectious Disease/s
- ◯ Kidney Conditions
- ◯ Tuberculosis

Other or further information including operations:

Does your child have any allergies? (If **Yes** please provide information below) ◯ Yes ◯ No

Is your child currently taking any medications? ◯ Yes ◯ No
(If **Yes** please provide information below (including if an Epipen is required)

Are there any main dental concerns for your child? (If **Yes** please provide information below ◯ Yes ◯ No

4. Social Media / Marketing Consent

In accordance with the Australian Privacy Principles (part 2- collection of personal information) I hereby give consent for the use of my child's photo / video material to be utilised by the company for the marketing/social media.

◯ Yes
◯ No

Initails

5. Treatments

I give Teeth On Wheels permission to do the following treatment(s) on my child if required:

- ◯ Check-up/Exam
- ◯ X-Rays
- ◯ Clean/Scale
- ◯ Fluoride Treatment
- ◯ Fissure Sealants
- ◯ Fillings

Please note treatment will only be completed if it is required and treatment descriptions are disclosed on our website. After your child's appointment you will receive a letter which will outline what treatment was completed and if anything further is required.

If your child requires anything of urgent matter, you will receive a call.

6. Declarations

By signing this form:

- I have completed the questionnaire to the best of my knowledge
- I understand that failure to make a full disclosure may place my child at undue medical risk or compromise their treatment
- I give my child permission to leave the facility to attend the Teeth On Wheels mobile dental clinic with a member of staff.
- I have a full understanding of the above treatment and would be happy for treatment to be completed if required on my child.
- I acknowledge that the use of surveillance cameras may be used in dental clinics operated by Teeth on Wheels to meet child safe requirements of schools and childcare partnerships

Parent/Guardian Signature

Date: D D M M Y Y

7. Dental Risk Assessment

1. How would you describe the condition of your child's mouth and teeth? Would you say...
   ◯ Excellent ◯ Very good ◯ Good ◯ Fair ◯ Poor
2. Does your child consume sugary drinks/ snacks? (E.g. Soft drink, fruit juices, flavoured milk, lollies, biscuits, chocolates etc.)
   ◯ Less than 1 time daily ◯ 1-2 times daily
3. When does your child usually consume sugary drinks and snacks?
   ◯ Between meals ◯ During meals
4. What is the usual source of drinking water for your child?
   ◯ Tap ◯ Well/Tank water ◯ Bottled water ◯ Other

5 How many times a day does your child brush their teeth?

◯ Less than 1 times daily ◯ 1 Times daily ◯ 2 Times daily ◯ 3 Times or more daily

6 Does your child have their own toothbrush?

◯ Yes ◯ No

7 Does your child use a tooth paste with fluoride in it?

◯ Always ◯ Sometimes ◯ Rarely or never

8 Does your child brush their teeth before they go to bed at night?

◯ Always ◯ Usually ◯ Sometimes ◯ Rarely or no

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.

Check-up/Exam $53.35, Fluoride Treatment $35, Clean/Scale $54.50- $90.85, Fissure Sealants $46.65, X-Rays $30.85, Fillings $116.95- $245.35

Declaration

- ✓ **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.**

Medicare Details Must Be Completed Below

medicare

CARD NUMBER

IRN NO FULL NAME OF CHILD

MONTH / YEAR

EXPIRY M M Y Y

Full name of person signing (if not patient)

Parent/Guardian Signature:

Date:

D D M M Y Y Y Y

Oral-B

TeethOnWheels™
a positive dental experience

Return forms by:

23/08/2021

School or Facility Name:

Seabrook Primary School

Fun for kids and easy for parents

We understand that finding time to take your child to see the dentist can be very hard and time consuming, which is why we provide the service of having dentistry coming to you. Your child will receive quality dental treatment from our highly trained and professional dental team, all of whom are working with children certified.

We will also provide information to your child about the importance of maintaining great oral health, and we will ensure your child loves coming back to the dentist.

Child Dental Benefits Schedule (CDBS)

With assistance from the Government, Medicare has introduced a Child Dental Benefits Schedule (CDBS) that provides children access to basic dental services from the ages of 2-17 years old. The entitlement is capped at $1,013 per child for every two calendar year period.

To be eligible, you or the child must be claiming one of the following benefits: Family Tax Benefits-Part A, Parenting Payment, Abstudy, Youth Allowance, Carer's Payment, Disability Support Pension, Special Benefits or Double Orphan Pension. To enquire if your child is eligible, please contact Medicare on 132 011.

Once your child's forms have been returned to your school and received by us, we will individually check each child's eligibility to see if treatment can be bulk billed through Medicare.

If your child is **not eligible** for the CDBS funding, Teeth On Wheels can offer a special deal that is only available through your school for a check-up, clean and fluoride treatment (and x-rays if required) for only **$99** (pre-payment required) which can be up to 30% cheaper then a private practice.
Our service also provides children to be seen under **Private Health Insurance**, as most providers will offer two free check-ups' and clean per family member each calendar year. To make a claim, you pay $99 to Teeth On Wheels and we will provide you with an invoice to claim your treatment back through your Private Health Fund.

Phone: (03) 9338 1191

www.teethonwheels.com.au

Email: info@teethonwheels.com.au

TeethOnWheelsAustralia #teethonwheels