Dental2You

Caring for your child's dental needs

DENTAL CHECK UP, CLEAN & TREATMENT
FOR CHILDREN AT OUR CENTRE

Dear Parent,

Your child will have the opportunity to have a dental check-up and treatment at our Centre provided by Dental2You.

Dental2you provides preventative services such as a comprehensive oral examination, clean to remove built up plaque and calcium application. Dental report, invoice and dental gift pack will be delivered to the centre the following week.

The services provided are **conveniently carried out at our Centre** making it **easy for you** to access this program and make your child's dental experience positive and comfortable in a familiar environment having their educators and friends close by as support.

Under the Federal Government's Child Dental Benefit Scheme if you receive Family Tax benefit A, your child will be eligible for the $1000 of funding for dental services every two years and there will be no cost involved. Funding is available for children aged 2 – 17 years of age.

If your child is not eligible for treatment under the CDBS, Dental2You will contact you to discuss alternative options and our $69 capped fee, to receive all the same services listed above which can be claimed through your private health fund provider if you have one.

Maintaining your child's oral hygiene is important to us.

We recommend this program to you and your family.
If you require any further information, please feel free to contact admin via email **admin@dental2you.net** or 0478 883 830
Visit Our Website www.dental2you.net to complete and submit forms online

Yours sincerely,
Centre Director

Dental2You

Caring for your child's dental needs

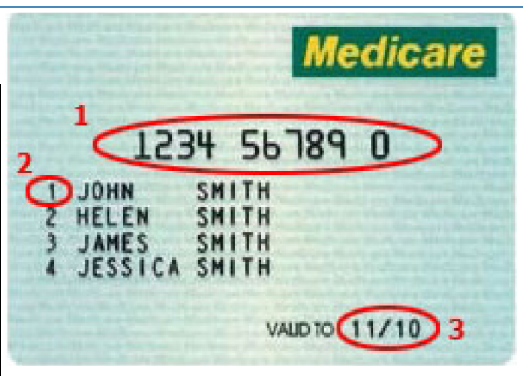
Consent Form

For treatment provided by Dental2You

Please fill in your child's details, sign and return this form to the center.

Childcare Centre				
First Name (as on Medicare Card)			**Last Name (as on Medicare Card)**	
Date of Birth (DD/MM/YY)	DD/MM/YY	**Gender** **M** **F**	**When did your child last visit the dentist?**	
Parent/Guardian Name			**Parent/Guardian contact number**	
Home address				
Email address				

Medicare Card Number (Number 1)										
Child Individual Reference Number (Number 2)										
Expiry Date (Number 3)										



Which days does your child attend childcare?		**Please tick attendance days below ✔**		
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**

Please tick:

- ❑ Please conduct Medicare eligibility check
- ❑ If eligible please provide my child an oral examination / clean / calcium application
- ❑ If not eligible, please contact me to discuss alternative options or
- ❑ I would like to take up the $69 fee for services listed above (please fill out your credit card information in the section on the next page or make payment calling admin directly).

We will provide you with a receipt and you can claim on your private health insurance if applicable.

Please specify your health fund……..

Do you consent to Dental2You taking photos of your child's dental treatment and being posted on Dental2You's Facebook and Instagram **Y / N**

Please sign below if you consent to us providing the above-mentioned services.

I am the Parent / Guardian **SIGNATURE: ✗ _____** **DATE: __ /__ /_____**

Office use only

Eligible	**88011**	**88012**	**88111**	**88121**	**88114**	**88161**
Amount						
Services Provided						
Dentist Name						
Checked						

MEDICAL HISTORY

Please provide child's details or discuss them with your dentist.

Information about your child's medical history is for your dentist's use ONLY.

Past /Current medical conditions: (Please tick)

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 hospitalized?	**Y**	**N**	Details:

Please indicate if your child has EVER had any of the following: (please tick)

	Y	**N**		**Y**	**N**		**Y**	**N**
Heart complaint/treatment			Asthma/bronchitis/lung conditions			Tuberculosis		
Rheumatic fever or heart valve surgery			Radiation therapy/chemotherapy			Nervous system disorder eg ADD		
High or low blood pressure			Thyroid disease			Infectious disease (measles/chicken pox) especially in the last three weeks		
Blood disorders/bleeding disorders			Hepatitis, jaundice or liver disease			Familial diseases		
Epilepsy			Treatment for any form of cancer			Kidney conditions		
Diabetes			Transplanted organ or bone marrow			Stomach or digestive conditions		

Other conditions (ADHD, Autism etc) or oral concerns not listed above that will assist us in providing appropriate oral health care for your child:

ALLERGIES (e.g. latex, penicillin, milk protein etc):	**Y**	**N**	Details:
Current Medications:	**Y**	**N**	Details:

I agree that the above is a true and accurate record.
Please note, this form is a guide only and you should discuss any relevant matters with your dentist prior to commencement of any dental treatments.

Child's First Name:	**Last Name:**
Gender (circle) Male Female	**Date of Birth: / /**

Parent/Guardian SIGNATURE: ✗ _____ DATE: __ /__ /_____

Payment Options

Payment must be made prior to dental visit or your child will not be seen. Cards will be processed the day before. Alternatively call admin 0478 883 830 to make a payment over the phone prior to your child's dental visit. If your child is not seen a refund will be made on the day.

❑ ***Credit Card Payments***

Name on Card															
Card Number															
Expiry Date						**CVV**					**$**				

CHILD DENTAL BENEFITS SCHEDULE
BULK BILLING PATIENT CONSENT FORM

PRIVACY STATEMENT

Dental2You respects your right to privacy and considers all of the information you have provided in this form to be personal information for the purposes of the Privacy Act 1988 (C'th) as amended ("Privacy Act").

Why Dental2You collects your personal information?

We collect your personal information primarily to enable us to provide Dental care services to you in the most appropriate and efficient way. We may also use this information to promote health and related services to you or for other purposes permitted under the Privacy Act.

How Dental2You collects your personal information

1. Where possible we collect your personal information directly from you and where that is not reasonably practicable we may collect your personal information from other sources.
2. By sending these forms to you.
3. In addition, we may collect personal information from Related Persons or health service providers such as health insurers, government agencies, hospitals, doctors and medical specialists.

We only use your personal information in accordance with National Privacy Principles.

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.

Australian Government
Department of Health

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 IRN

✗ _____

Parent/ Guardian signature

_____

Patient's full name

_____

Full name of person signing

Date_____/_____/_____

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