



Your child could be entitled to \$1000 of **free** dental care!!!

From Wednesday 11th until Friday 13th November

Medicare's Child Dental Benefits Schedule (CDBS) covers part or the full cost of some dental services for children if you get certain payments from Medicare.

To be eligible for this your child must be:

- 2 to 17 years old for at least 1 day that year
- eligible for Medicare
- getting a payment from Medicare at least once a year, or have a parent getting a payment from Medicare at least once a year.

The services covered by Medicare will include:

- check-ups
- X-rays
- cleaning
- fissure sealing
- fillings
- extractions

**PLEASE HAVE FORMS RETURNED BACK TO SCHOOL OFFICE
ASAP OR BY OCTOBER 30TH 2020**

INFORMATION FOR PARENTS

MOBILE DENTAL CLINICS AUSTRALIA (MDCA):

Mobile Dental Clinics Australia (MDCA) is a wholly Australian owned company providing mobile emergency, general and dental laboratory services throughout Melbourne and Victoria.

We are a mobile provider of dental check-ups, treatments and education to students at their school. Our team of qualified, accredited and experienced dental practitioners will provide on-site, general dental care to students, both those covered by the Child Dental Benefits Schedule (CDBS) and those who choose the fee-paying option.

We offer convenient, affordable and professional services to students. By attending regular check-ups from an early age, we hope to provide early intervention and essential care to your children.

FEE AND CHARGES (NO CHARGE TO PARENT):

The Child Dental Benefits Schedule (CDBS) is administered by the Department of Human Services under Medicare. For eligible children aged 2 – 17, the total benefit entitlement is capped at \$1,000 per child over a two-year calendar period. The CDBS is means-tested and the child's household must be in receipt of Family Tax Benefit A or a relevant Australian Government payment to be eligible.

www.humanservices.gov.au/health-professionals/services/child-dental-benefits-schedule/

[https://www1.health.gov.au/internet/main/publishing.nsf/content/42FC28F2797C4A10CA257BF001A35F6/\\$File/Guide%20to%20the%20Child%20Dental%20Benefits%20Schedule.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/content/42FC28F2797C4A10CA257BF001A35F6/$File/Guide%20to%20the%20Child%20Dental%20Benefits%20Schedule.pdf)

PLEASE SEE LINK ABOVE FOR MORE INFORMATION

The following services can be provided to eligible students:

- Oral examination, clean and fluoride application
- Fissure seals
- Temporary and permanent fillings
- Education
- Treatment plan for parents

If a student does not qualify for CDBS, we can offer preventative care for \$99.00. Payment is available via EFT or Credit Card. Receipts will be provided for Health Fund Claims.

- Oral examination, clean and fluoride application
- Education
- Treatment plan for parents

Additional care:

If students seen are found to require additional treatment, their parent/guardian will be contacted. Additional treatments may include fillings, extractions, x-rays.

PLEASE COMPLETE THE ATTACHED CONSENT FORM AND MEDICAL HISTORY QUESTIONNAIRE RETURN TO YOUR SCHOOL TO ENSURE YOUR CHILD DOES NOT MISS OUT ON A DENTAL VISIT.

CHILD CONSENT FORM

Information about the Student:

Please complete all fields in **BLOCK LETTERS**

School Name	CRIB POINT – PLS RETURN TO OFFICE ASAP		
Family Name		First Name	
Gender (Please Circle)	Male Female	Date of Birth	
Grade/Class		Teacher	
Parent/Guardian Name		Contact Number	
Home Address <small>Your child's report from the dentist will be sent to this address.</small>			
Email Address			

Medicare Card Information:

Medicare Number	
Child Individual Reference Number	
Expiry Date	



Consent:

1. Please tick the box (if you agree):

Please conduct a Medicare eligibility check for my child

Please tick the boxes (if you agree to **free** treatment covered by CDBS):

If my child is eligible, please provide **FREE** treatment covered by CDBS:

- | | | |
|--|---|--|
| Free
Free oral health education <input type="checkbox"/> <input checked="" type="checkbox"/>
<small>NO CHARGE TO PARENT FOR YOUR INFO ONLY</small> | Free
Oral examination <input type="checkbox"/> <input checked="" type="checkbox"/>
<small>(88011)</small> | Free
Scale, clean and fluoride <input type="checkbox"/> <input checked="" type="checkbox"/>
<small>(88114) (88121)</small> |
| Free
Fissure Seals <input type="checkbox"/> <input checked="" type="checkbox"/>
<small>(88161 / 88162)</small> | Free
X-Ray <input type="checkbox"/> <input checked="" type="checkbox"/>
<small>(88022)</small> | |

If any further treatments are necessary (i.e.: extraction) MDCA will contact the parent/guardian.

2. Please tick the box (if you agree):

If my child is not eligible or has reached their Medicare cap.

I consent to paying **\$99.00** for oral health education / an oral examination / scale / clean / treatment plan. MDCA will contact parent/guardian for payment and will discuss any additional treatments that may be required after check-up completed. A receipt will be provided for claims for private health insurance.

MEDICAL HISTORY QUESTIONNAIRE

This information is for your dentist's use only. Please complete below

Past/Current medical conditions (if any)?		
Do you have any allergies?	Y / N	Details
Have you had any serious or ongoing illness?	Y / N	Details
Have you ever been hospitalised?	Y / N	Details
Are your immunisations up to date?	Y / N	Details
Current medications (if any):	Y / N	Details

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

Infectious disease (measles/chicken pox) If so, when?	Y/N	History of needing to take antibiotics before dental treatment	Y/N
Stroke	Y/N	Tuberculosis	Y/N
Contact with HIV/AIDS virus	Y/N	Stomach or digestive condition	Y/N
Growth disorder	Y/N	Nervous condition e.g. ADHD	Y/N
Epilepsy	Y/N	Diabetes	Y/N
Radiation therapy	Y/N	Kidney disease	Y/N
Steroid therapy	Y/N	Hepatitis or other liver disease	Y/N
Asthma	Y/N	High or low blood pressure	Y/N
Rheumatic fever	Y/N	Heart valve disorder	Y/N
Thyroid disease	Y/N	Pacemaker	Y/N
Prosthetic implant	Y/N	Anemia, leukemia or any other blood disorders/excessive bleeding	Y/N
Comments if yes to any of the above:			

This form is to be used as a guide only and should you wish to discuss any relevant matters, please contact your dentist prior to visit.

I agree that the above information is accurate and true. By signing below, I consent to my child receiving all treatments as recommended by the Dentist.

Child's Name:		Date of Birth:	
Parent/Guardian Signature:		Date:	



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