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THE MOBILE DENTAL VAN IS COMING!

FREE DENTAL*

SMILE PATROL©
MOBILE DENTAL

THE DENTAL TEAM IS COMING TO YOUR SCHOOL!

WHAT DO I NEED TO DO? - FILL IN THIS FORM AND RETURN TO SCHOOL

Please fill in this form and return to your school so your child does not miss out on free dental care!

WHAT DOES SMILE PATROL DO?

1. MEDICARE ELIGIBILITY CHECK: ✔

We will check your child's eligibility for the Child Dental Benefits Scheme (CDBS) with Medicare to determine if they qualify for Medicare-funded dental treatment.

2. WE VISIT YOUR SCHOOL!

Our dental van visits your school and our dental practitioners conduct dental check-ups. A standard check-up for eligible students can include a dental examination, tooth cleaning, 2 x bitewing x-rays, tooth remineralisation and if necessary fissure sealants (with parental consent).

3. RECEIVE A TREATMENT PLAN VIA EMAIL

After the check-up we will send you a treatment plan detailing what treatments have been provided and recommendations for further dental treatment that may be required.

COMPLETE IN CAPITAL LETTERS PLEASE (If details are incorrect or missing, we may not be able to see your child) INCOMPLETE FORMS WILL BE NOT BE PROCESSED

School Name:

Grade/ class (Year level and letter e.g. 2A MUST COMPLETE)

Child's First Name:

Childs Last Name:

Childs Date of Birth: Day / Month / Year:

Child's Address: Number Street

Suburb: Postcode:

Parent/Guardian 1 Full Name:

Parent Guardian 1 Email:

Parent/Guardian Mobile:

Parent/Guardian 2 Full Name:

Parent/Guardian 2 Email:

Parent Guardian 2 Mobile:

MEDICAL AND DENTAL HISTORY FORM

Please tick 'Yes' if your child has any of the following medical conditions			
	Yes		Yes
Respiratory disease – e.g. Asthma, Cystic fibrosis, TB		Fainting /dizziness	
Heart condition e.g. Murmurs or a congenital deformity		Seizures or epilepsy	
Heart Surgery e.g. valve replacement or pacemaker		Musculoskeletal disorders e.g. Juvenile arthritis	
Diabetes – If so what type?		Bone / Joint replacement	
Rheumatic fever		Hep A, B or C (please circle)	
Treatment for cancer e.g chemotherapy or radiotherapy		HIV	
Excessive bleeding or blood disorder e.g anaemia or haemophilia.		Do they smoke or vape? Please circle	
Head or neck injuries		Is or could the student be pregnant?	
Liver Disease		Gastric conditions e.g Reflux	
Kidney Disease		Any Other Surgery?	

Is the student currently taking any medications? ☐ Yes ☐ No
This includes any prescribed inhalers such as Ventolin for Asthma (Please list below)

_____

_____

_____

Does the student have any allergies?
☐ Yes ☐ No (If yes, please write the medication below and what reaction they have had.)

_____

Does the student have any care needs or disabilities we need to consider when we are providing dental care? ☐ Yes ☐ No (If yes please provide more information below)_____

_____

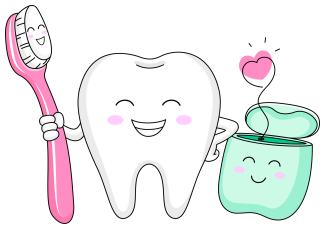
Please tick 'Yes' if your child has any of the following dental conditions	
	Yes
Dental pain in their mouth	
Difficulty drinking?	
Snoring loudly	
Difficulty speaking due to a problem with their teeth?	
Known Cavities?	
Any difficulty smiling or showing teeth?	
Any extractions or dental treatments in the past?	

Is the child under the care of a dentist or undergoing any treatment at present? ☐ Yes ☐ No

Is there anything else you would like us to know before we provide any dental care to your child? ☐ Yes ☐ No
If yes to any of the above, please provide more details:

TOOTH DECAY SCREENING:

Has the student had any fillings or teeth removed due to tooth decay? ☐ Yes ☐ No
Does the student wear any orthodontic appliance? E.g. retainer, night guard etc
How often does the student brush their teeth?
☐ Once a day morning
☐ Once a day evening
☐ Twice a day
Has the student had any fluoride applications by a dental clinician to their teeth in the last 6 months? ☐ Yes ☐ No
Has the student had any x-rays in the last 6 months?
☐ Yes ☐ No



Australian Government
Department of Health

CHILD DENTAL BENEFITS SCHEDULE & MEDICARE BULK BILLING CONSENT

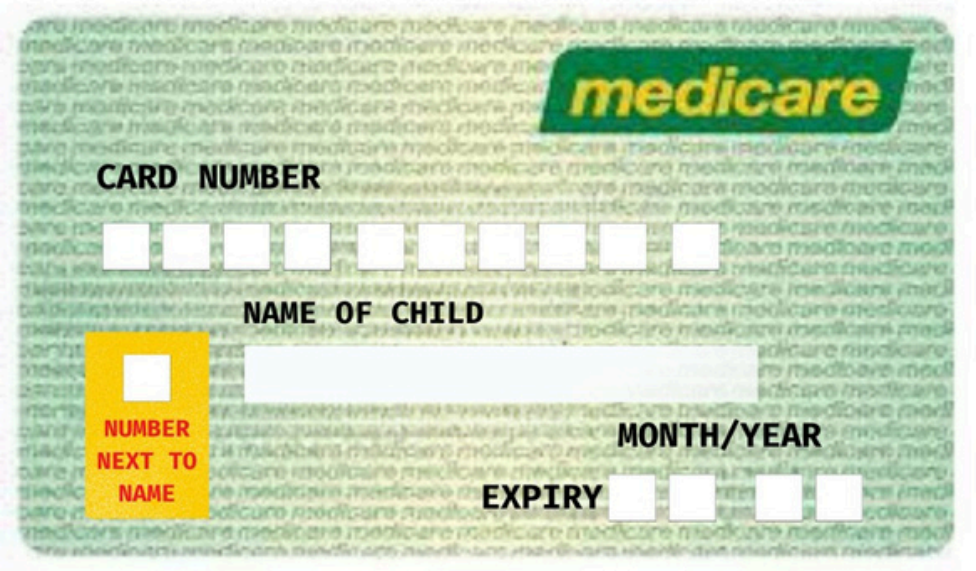
I, the patient / legal guardian, certify that I have been informed:

- 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.

If my child is not eligible under CDBS I agree to a free Medicare Bulk Billed Oral Health Examination and Education



Full name of person signing (If not the patient) PRINT NAME

Full name of person signing SIGN HERE

_____/_____/_____ Date

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

CONSENT FORM FOR DENTAL CARE

I give consent for my child: PLEASE WRITE IN BLOCK LETTERS (WRITE CHILD'S NAME)

First Name: _____

Last Name: _____

to participate in the Smile Patrol school dental program.

I agree that I have, to the best of my knowledge, provided Smile Patrol with all the relevant health and personal information that is required to provide appropriate care. In giving consent, I agree that I have read the consent form and the attached Smile Patrol information sheet. I have enough information to understand the following:
Dental Services: The types of dental services offered by Smile Patrol, including the benefits and risks involved, where the services will take place, and who will be providing them.
Bulk-billing patient consent: I will not pay any out-of-pocket costs for services provided by Smile Patrol under the CDBS.

Dental Care Consent:

Please indicate your consent by ticking the appropriate boxes:

- Dental X-rays ☐ 

I consent to up to 2 small dental x-rays if needed.

- Fissure Seals/Fillings ☐ 

I authorise the placement of protective fissure seals or fillings on my child's permanent molars, up to a maximum of 8 seals, if deemed necessary by the dental practitioner.

(Guardian's oral consent will be obtained via phone call beforehand.)

Parent/guardian/student Full name:

_____

Parent/guardian/student: Signature:

_____

_____/_____/_____ Date

Privacy: I have read and understood the privacy information in this pack and acknowledge how the program will manage student healthcare information.
Care after dental services: A Smile Patrol clinician or school staff may contact a parent, legal guardian, or carer if a student becomes unwell at school after receiving dental services, or if they require additional care that cannot be managed at school.
If you do not consent to specific treatments, please specify below:

** Students aged 18 years and over, and those who are considered a mature minor for the purpose of accessing dental services can consent for themselves. This consent is valid for 12 months from the date it is signed.*

We sincerely appreciate your commitment to your child's dental health. Thank you for entrusting us with the care of their smile at school!

PLEASE COMPLETE THIS FORM AND RETURN TO SCHOOL