DENTAL & VISION CONSENT FORM

Happy Smiles & Clear Visions For Children At School Program

PEOPLES HEALTHCARE
Mobile Dental Services

PEOPLES HEALTHCARE
MOBILE OPTOMETRY SERVICES

PATIENT DETAILS

Full Name:		Gender:	
Date of Birth:		Class/Grade:	
Child's School Name:			

MEDICARE DETAILS

Medicare Card Number:			
Individual Child Ref no:		Expiry date:	

DENTAL TREATMENT CONSENT

Peoples Healthcare will provide dental services at no out-of-pocket cost if your child is eligible for Medicare Child Dental Benefits Schedule (CDBS).This service will be Bulk-Billed. Please select below:

☐	If eligible for CDBS, I parent/guardian give consent for my child to receive dental treatments from Peoples Healthcare dental practitioners which includes Comprehensive Oral Exam, Clean (removal of plaque or calculus), Fluoride application, X-ray and Fissure Sealants for prevention.
☐	I give consent for my child to receive further treatment which may be needed such as dental fillings. If eligible for CDBS.
☐	If not eligible for CDBS, please provide basic dental check-up to my child (exam, clean & fluoride) for $119+gst.

EYE TREATMENT CONSENT

Peoples Healthcare will provide optical services at no out-of-pocket cost if your child is eligible for Medicare. Please select below:

☐	I parent/guardian give consent for my child to receive a Comprehensive Eye Exam. (this service will be bulk-billed NO-GAP payable through Medicare if your child hasn't had an eye exam in the last 3 years)
☐	Please provide a full eye exam for my child and bill me a GAP payment of $50+gst. If my child has had an eye exam in last 3 years.

PARENT / GUARDIAN DETAILS

Full Name:		Relationship with Patient:	
Residential Address:			
Mobile:		Email:	

PATIENT MEDICAL HISTORY

Please circle YES/NO and provide details. Medical details are only for health professional's use.

Does your child has any serious medical condition?	**YES / NO**	Details:
Is your child currently taking any medications?	**YES / NO**	Details:
Does your child have any allergies?	**YES / NO**	Details:
How is your child's current Oral Health?	**GOOD / FAIR / POOR**	Details:
When did your child last visit a dentist?		Details:
How is your child's current Vision Health?	**GOOD / FAIR / POOR**	Details:
When did your child last have an eye exam?		Details:

PARENT / GUARDIAN CONSENT

By signing below I, Parent/Guardian give consent to peoples healthcare to provide above mentioned dental and optical services to my child at their school.

Parent/Guardian Name:			
Signature:		Date:	

Privacy Statement: The information provided to us in this document is protected under the Information Privacy Act 2000 and Health records Act 2002. We won't disclose your information to any third party however some information may be shared with Medicare to check or access the health service your child has received.

Peoples Healthcare Services | Ph: 1300 425 502 | E: services@peopleshealthcare.com.au | W: peopleshealthcare.com.au

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.