TOOTHFAIRY DENTAL CARE

Consent Form

Patient Details

Centre Name/Suburb:		Classroom:
Days at Centre (tick) : Mon ⬜ Tues ⬜ Wed ⬜ Thurs ⬜ Fri ⬜		
Child's Full Name:	Date of Birth:	Gender:

Medicare Details

If the patient does **not** have a Medicare card, please leave this section blank.

Medicare Card Number:	**(10 digit number)**
Medicare Ref Number:	**(individual number next to name)**

Please tick the appropriate boxes you wish to proceed

Not all children are eligible for Medicare bulk billed Child Dental Benefit Schedule (CDBS). However, we offer the same services to all children at a small fee. We are able to check the eligibility of your child with their medicare details provided above. Please select down below with options you would like.

For ELIGIBLE CDBS ⬜ - conduct an oral examination, a dental clean (removal of plaque and/or calculus, and apply fluoride varnish to remineralise your teeth if needed.

Choose one **option available if your child is NOT ELIGIBLE for CDBS and would still like to be seen:**

1 ⬜ - Do Nothing.

2. ⬜ - Conduct simply an oral examination for a price of $55. This includes exams of teeth, muscles, soft tissues, gums and bite.

3. ⬜ - Conduct an oral examination, a dental clean (removal of plaque and/or calculus, and apply a fluoride varnish to remineralise your teeth if needed for a fee of $80.

Payment Details if child is NOT covered by CDBS

Once your child has been seen payments can be made via directly over the phone., or an invoice with a secure payment portal SMS to you. Alternatively, you can provide your information below and it will be processed automatically at the end of the day.

Debit/Credit Card Number:	Expiry:	CCV:

Private health ⬜ Yes ⬜ No

If you have private health insurance an invoice will be provided at the end of the day via email where you can claim reimbursements from your health care fund depending on your level of insurance.

Parent/Guardian Details

Full Name/Relationship:	Contact Number:

Email:
Residential Address:

Emergency contact details: ⬜ Same as Parent or Guardian mentioned above OR

Name: Relationship: Contact Number:

Patient Medical History

We ask about these medical conditions as they can impact a child's dental health or the dental care we provide. We realise that some of these questions are very personal. Please provide information to the best of your knowledge.

1. Does the patient have any allergies? This includes food, medicines, and/or products. e.g. latex, artificial flavours, milk protein (casein). ⬜ Yes ⬜ No - If yes, please provide details:

2. Is the patient currently taking any medications? ⬜ Yes ⬜ No - If yes, please provide details:

3. Are there any illnesses or limitations that we should take into account when treating the patient? a physical disability, such as the need for a wheelchair, an intellectual or sensory impairment, or a mental or psychological disorder.

   ⬜ Yes ⬜ No - If yes, please provide details:

4. Are there any dental concerns? ⬜ Yes ⬜ No - If yes, please provide details:

Medical Questionnaire

Please tick if the student has ever had any of the following:

Respiratory disease e.g. asthma, lung disease, TB (tuberculosis)	Yes ⬜ No ⬜	Heart surgery e.g. artificial heart valve, pacemaker	Yes ⬜ No ⬜
Heart condition or heart murmur	Yes ⬜ No ⬜	Rheumatic fever	Yes ⬜ No ⬜
Low or high blood pressure	Yes ⬜ No ⬜	Treatment for cancer, including chemotherapy or radiation therapy Yes ⬜ No ⬜	
Excessive bleeding or blood disorder	Yes ⬜ No ⬜	Injury to head, neck or spine	Yes ⬜ No ⬜
Seizures or epilepsy	Yes ⬜ No ⬜	Diabetes: What type?	Yes ⬜ No ⬜
Hepatitis A, B or C	Yes ⬜ No ⬜	Kidney Disease	Yes ⬜ No ⬜

Declaration

⬜ I acknowledge that all information I provided in this form is true and accurate.
⬜ I acknowledge failure to make full disclosure of medical health may result my child at medical risk or compromise their treatment.
⬜ I consent to allow my child to participate in Toothfairy Dental Care program and perform the selected dental services as ticked above.
⬜ I acknowledge the services will be conducted at the center premises by a registered Dental Practitioner.
⬜ I consent to allow Toothfairy Dental Care to take photos of my child's participation and to allow it for social media use.

Parent/Guardian
Full Name: Signature: Date: