My School Dentist

Patient Details & Medical History

School/Site Name

A. Patient Details

Full name of Patient (as shown on Medicare Card)

Preferred Name

Date of Birth

Student's Gender

☐ Female ☐ Male ☐ Not specified

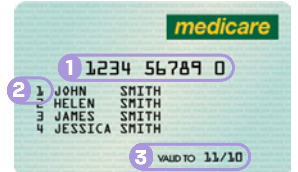
When did the patient last visit the dentist?

Address

1. Medicare Card Number

2. Line Number

3. Valid to



Private Health Fund Provider Name (if applicable)

Emergency Contact Name

Phone Number

Does the patient have (or have they had) any of the following conditions? Please tick Yes or No.

Condition			Condition		
Allergic to Penicillin	☐ Yes	☐ No	Heart trouble of any kind	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hepatitis A, B or C	☐ Yes	☐ No
Bleeding or Blood Disorders	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	HIV (AIDS)	☐ Yes	☐ No
Does the Patient snore?	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Women: Are you pregnant?	☐ Yes	☐ No

If the Patient is taking any **medication**, has **any known allergies** or any other **serious illnesses with adverse reactions** to prior dental treatment, please detail here (and overleaf if necessary):

B. To be completed by Parent or Guardian where Patient is younger than 16

Parent/Guardian Full Name

Phone Number

Mobile Phone Number

Address (if different to the patient)

Email

Would you like to attend your child's appointment?

☐ Yes ☐ No

☐ I do not wish to receive any marketing communications from the ADF and partner clinics.

C. Confirmation

I, (Insert your name) confirm that I am the ☐ Father ☐ Mother ☐ Legal Guardian ☐ Student (if over 16) of, (Insert your child's name) and hereby consent to a dental exam by the Australian Dental Foundation at their school in addition to the following services ☐ x-rays ☐ fluoride ☐ teeth cleaning.

Signed **Date**

If any further treatment is required, we will contact you to discuss the options available and obtain consent prior to performing any additional treatment.

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.