W&L MOBILE HEALTHCARE services

STUDENT CONSENT FORM

School Name: _____ Year level: _____ Class:_____

Students Personal Details

Surname: _____ Birth Name: _____ **DOB:** _ _ / _ _ / _ _ _ _

Gender: Male / Female (Please circle)

Medicare Number: _ _ _ _ _ _ _ _ _ _ _ Reference Number: _ _ EXP: _ _ / _ _ _ _

I give consent to W&L Mobile Dentistry to perform Comprehensive Oral Exam, Scale & Clean, Flouride Treatment, Hygiene Education and X-Rays if needed, to my child at school? Yes/ No (Please circle)

I would you like to attend my child's appointment? Yes/ No (Please circle)

Are you of Aboriginal or Torres Strait Islander descent? Yes/ No (Please circle)

Parent/Guardian/Emergency Contact

Full Name: _____ Relationship: _____Phone: _ _ _ _ _ _ _ _ _ _

Address: _____ Email: _____

Medical Practitioner

Doctors Name: _____ Phone: _ _ _ _ _ _ _ _ _ _

Practice Address/ Name (if known): _____

Medical Details

Please tick if you have/had any of the following medical conditions

Heart Problems		**Chronic Conditions**		**Infectious Diseases**		**Other**	
High blood pressure	☐	Diabetes	☐	Tuberculosis	☐	Epilepsy	☐
Bleeding disorder	☐	Asthma	☐	Hepatitis A, B, C	☐	Kidney disorder	☐
Artificial heart valve	☐	Cancer	☐	Other (specify) _____			☐

Are you currently being treated for any condition by a Doctor/Psychologist/Health Worker? Yes / No (Please circle)

Please list all details of medical conditions of concern (not listed), prescribed and over the counter medications or other drugs you are currently taking.

_____

_____

Allergies (Please list all including medications)

Are you allergic to anything e.g. local anesthetic, latex, penicillin, peanut etc. (please specify)

_____

_____PTO

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Do you have any conditions or disabilities that may affect your treatment? (Please list)

_____

_____

Please list any operations that you have had in the past 12 months.

_____

_____

Declaration

I have accurately completed this pre-clinical questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place my child at undue medical risk or compromise their treatment.

I hereby give my authority for any treatment agreed upon by me, to be carried out by W&L Mobile Healthcare dentists an their staff and I assume full financial responsibility for treatment when my child's CDBS (Child Dental Benefit Scheme) limit is reached.

Parent/Guardian Signature: _____ **Date:** _____

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.