WHITE CROSS MOBILE DENTAL CARE PROGRAM PROVIDES PREVENTATIVE DENTISTRY TO ALL SCHOOL AGED CHILDREN

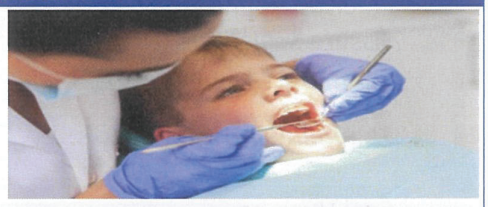
Oral Health is an important part of a child's development and well-being. Oral Health problems that aren't diagnosed or treated can cause pain that interferes with a child's ability to eat, sleep, play, and function at home or school.

Preventative Dental Care will reduce the risk of cavities, gum disease and other dental issues. Improving a child's oral health requires practicing a good oral hygiene routine and regular dental visits.

NON-INVASIVE PREVENTATIVE DENTAL TREATMENT LIST

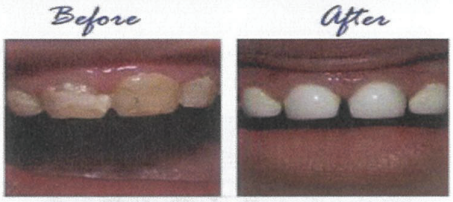
Comprehensive Oral Examination

Comprehensive Oral Examination will involve a thorough soft tissue examination and assessment of your child's teeth and gums by using a small mirror and explorer. This is to check for tooth decay or other potential problems which may impact on your child's health. The Dental Practitioner will discuss the importance of good oral hygiene and a balanced healthy diet.



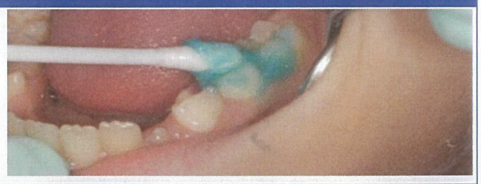
Scale / Clean / Polish

A dental clean involves removing plaque (soft, sticky film containing bacteria) and tartar/calculus (hardened plaque) deposits that built up on the teeth over time. The purpose of the cleaning and polishing is to leave the surfaces of the of the teeth clean and smooth so the bacteria is unable to stick, keeping the teeth and gums healthy and help avoid tooth decay.



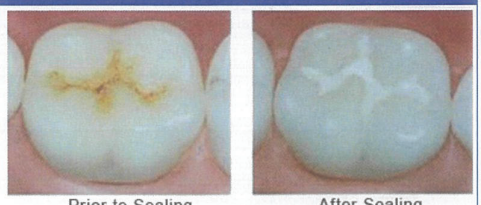
Fluoride Application

Fluoride is a mineral that helps strengthen your teeth and also can prevent tooth decay by making the tooth resistant to acid attacks from plaque, bacteria and sugars in the mouth. Fluoride may reduce cavities and help to repair the early stages of tooth decay.



Fissure Sealants

Fissure sealants are a safe and non-invasive way of protecting your child's teeth. When the permanent molars are fully erupted it is recommended for preventing tooth decay. The sealant is a resin or glass ionomer which is placed on the chewing surface of the molar teeth, the sealant forms a hard shield that prevents food and bacteria invading the deep grooves in the teeth.



Prior to Sealing | After Sealing

Fees & Charges

Children covered under The Child Dental Benefits Schedule (CDBS) will be bulk-billed. If your child is not covered or has insufficient funds or has reached the benefit cap the preventative treatment will be provided with **no out-of-pocket costs**.

Parent/Legal Guardian Consent

Please complete the following consents forms for your child to participate in our Preventative Dental Treatment Program. *(Treatment will be provided only if clinically diagnosed)*
1) CDBS Consent Form Pg 3. 2) Preventative Treatment Request Form A5 (attached)

Assessment Letter

An assessment letter will be issued outlining your child's Oral Hygiene the Dental Treatment provided by the Dental Practitioner and further recommended Dental Treatment to be followed up with your preferred or local dentist.

White Cross Mobile Dental Care

Child Information Form

Surname | Given Name/s | Date of Birth (DD / MM / YYYY)

Address | Suburb | Postcode

Gender ☐ Male ☐ Female | School Name | Class

Medicare Card Number | Child's Reference No | Medicare Expiry Date

Medical Information

Please ☑ to indicate if your child has or have not had any of the following medical conditions.

	Yes	No		Yes	No		Yes	No
Asthma	☐	☐	Abnormal Bleeding	☐	☐	Bronchitis	☐	☐
Epilepsy	☐	☐	Diabetes	☐	☐	Fainting/Dizziness	☐	☐
Hepatitis B or C	☐	☐	Rheumatic Fever	☐	☐	Radiotherapy/Chemotherapy	☐	☐
High Blood Pressure	☐	☐	Seizures	☐	☐	Sores or Ulcers in mouth	☐	☐

Allergies e.g. (Latex, Dairy)

List other Medical Conditions

List your Child's Medications

Dental Information

When did your child last visit a dentist? ☐ Less than 6 months ☐ More than 6 months ☐ Never

Has your child had dental x-rays in the last 12 months? ☐ Yes ☐ No ☐ Unsure

Does your child have a regular dentist? ☐ Yes ☐ No

How does your child feel about having a dental examination?
☐ Extremely Nervous ☐ Mild case of nerves ☐ Relaxed and confident

Parent/Legal Guardian Information

Surname | Given Name/s | Relationship to Child

Contact Number | Email Address

Questions & Further Information

If you have any questions regarding your child's treatment & costs, please do not hesitate to contact Christine our School Liaison Manager on **0414 570 785** or email us at: ***info@whitecrossmobiledentalcare.com***

White Cross Mobile Dental Care

Office Use Only:	Completed by Dental Practitioner

Dear Parent / Guardian

_____ had an oral examination on _____

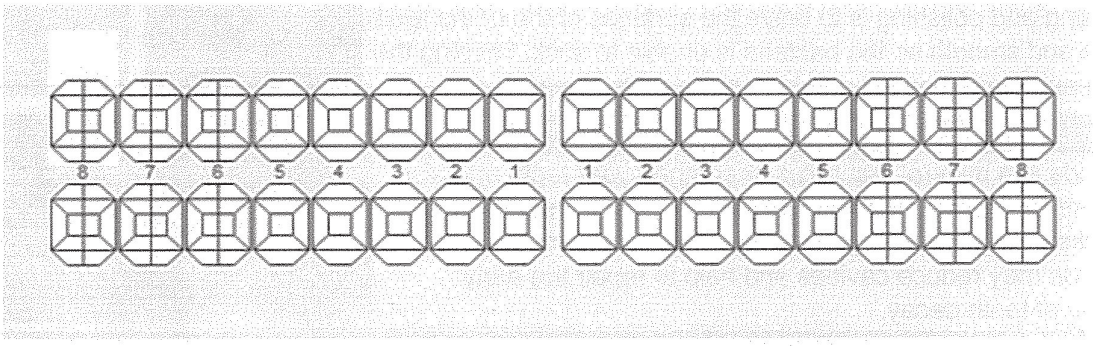
The following dental treatment was provided:

Comprehensive Oral Examination ☐
Scale / Clean / Polish ☐
Fluoride Application ☐
Fissure Sealants/s (FS) ☐
Temporary Filling/s (TF) ☐

The following diagnosis is:

Oral Hygiene:
Poor ☐ Fair ☐ Good ☐

Provided Dental Treatment / Recommended Follow-up Dental Treatment



Clinical Notes:

_____

_____

_____

Please present this letter to your preferred or local dentist for recommended follow-up dental treatment.

If you have any further enquiries please don't hesitate to call or email.

Chang Hoo Park
Dental Practitioner

White Cross Mobile Dental Care
PO Box 334, HORNSBY NSW 1630
Ph: 0414 570 785
Email: info@whitecrossmobiledentalcare.com

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.
(White Cross Mobile Dental Care – DO NOT charge any additional costs)

Patient's Full Name

Patient / legal guardian signature

Patient Medicare Number

Print full name of person signing

Number on Card

Valid to

Date: _____

Office Use:	Clinical Notes:	DOS:

White Cross Mobile Dental Care

FORM MUST BE COMPLETED BY PARENT/GUARDIAN BEFORE DENTAL TREATMENT

PREVENTATIVE DENTAL TREATMENT CONSENT & REQUEST FORM

I, the Parent / Legal guardian, give consent for my child (insert child's name) _____to receive the following non-invasive preventative dental treatments, provided by the Dental Practitioner.

PREVENTATIVE DENTAL TREATMENT REQUEST FORM

Treatment Description	*Yes*	*No*	*Item No*	*CDBS Value*
Comprehensive Examination *First Visit - Required for Assessment*	☑	☐	*88011	$59.60
Periodic Examination *Subsequent Visit - Required for Assessment* *Only one service claimable.	☑	☐	*88012	$49.55
PLEASE COMPLETE ☑	**YES or NO**			
Clean – Remove plaque Clean – Remove calculus *Only one service claimable. *Clean - Removal of plaque and/or calculus will be determined by the Dental Practitioner.	☐	☐	88111 88114	$60.90 $101.55
Fluoride Application	☐	☐	88121	$39.15
Fissure Sealants (FS) *(Maximum x 4 - molar teeth)*	☐	☐	88161	$52.15 *(per tooth)*
Temporary Filling (TF) *(Maximum x 3 - all teeth)*	☐	☐	88572	$55.20 *(per tooth)*

Fees & Charges

I understand that the benefits will be covered under the Australian Government Child Dental Benefits Schedule (CDBS), **with no out-of-pocket expenses**, even once the benefits are exhausted and/or the child is ***not*** covered by this Scheme (Medicare)

Parent/Guardian (Full Name)	Parent/Guardian Signature	Date

Please Sign

PO Box 334 Hornsby NSW 1360
Ph: 0414 570 785
Email: info@whitecrossmobiledentalcare.com