FAQ'S

Do I need to pay anything for a dental check-up?
There's no out of pocket charge for dental check-ups and preventive care under the Child Dental Benefits Schedule.

Do I need to attend the appointment with my child?
Parents aren't required to attend, but if you want to accompany younger kids, please let us know in advance.

What if I do not have a Medicare card?
If you don't have a Medicare card, your child can get a FREE dental checkup through VMDH. We'll give you a report if your child needs more treatment

What services are provided during the school dental check-up?**
VMDH Mobile dental care includes dental exams, cleanings, fluoride treatments, and preventive care like sealants. In addition, we teach you how to take good care of your teeth.

What if my child has special dental needs?
Our team of qualified dental professionals has extensive experience in handling a variety of dental needs and conditions. During the registration process, please let us know if your child has specific needs.

GUIDE TO MEDICARE BULK BILLING

ZERO out of pocket cost

Item	Service	CDBS Bulk-Bill Fee	Out of Pocket Cost
88011	Comprehensive Oral Examination	$57.65	$0.0
88012	Periodic Oral Examination	$47.90	$0.0
88013	Limited Oral Examination	$30.10	$0.0
88111	Removal of Plaque / Stain	$58.90	$0.0
88114	Removal of Calculus- 1" visit	$98.20	$0.0
88115	Removal of Calculus-2" visit	$63.85	$0.0
88121	Topical Remineralisation agents	$37.85	$0.0
88022	Periapical or Bitewing X-ray	$33.35 ea	$0.0
88311	Removal of Tooth or Part (s)	$143.75	$0.0
88161	Fissure and/or Tooth surface sealing	$50.45 ea	$0.0
88162	Fissure and/or Tooth surface sealing (for additional fissure sealing)	$25.25 ea	$0.0
88311	Extraction of tooth (non-surgical)	$143.75	$0.0

Medicare CDBS provides children aged 2-17 funding of $ 1095 for preventative dental treatment and is renewed every 2 calendar years. This service is covered under Medicare, meaning Medicare will cover these costs and you do not have to pay for them out of pocket.

You can withdraw your consent for CDBS at anytime by contacting VMDH. For more information regarding CDBS, please visit www.humanservices.gov.au/childdental

VMDH will check eligibility before treatment. If you give consent, upon an initial examination (88011) the Medicare Benefits amounts for each service we may further provide are listed if they are required.

Pricing is set by the Department of Health and is deducted from your Medicare balance. This is paid by Medicare. You do not need to pay these amounts.

Please visit www.vmdh.com.au for details of what each treatment involves.
Please visit https://victorianmobiledentalhealth.com.au/privacy-policy to view our Privacy Policy.
If you have any questions, please contact on **0483 102 562** on **03 9431 3150**

VMDH
VICTORIAN MOBILE DENTAL HEALTH

medicare

ADA AUSTRALIAN DENTAL ASSOCIATION

HAPPY MOUTH IS A HAPPY MIND

FREE* Dental Check-Ups & Preventive Care *Right at School!*

How to Register

Option 1

Fill this paper form and handover to the school staff

Option 2

Scan this QR code to Register Online

17/43 Scanlon Drive, Epping 3076 VIC
admin@vmdh.com.au

**Bulk-Billed Services Under the Child Dental Benefits Schedule*

0483 102 562 03 9431 3150

MEDICAL HISTORY & CONSENT FORM

VMDH VICTORIAN MOBILE DENTAL HEALTH

STUDENT DETAILS:

First Name :

Last Name :

School Name :

Year : Group :

Gender : *Male* *Female* *Other*

Date of Birth :

PARENT/GUARDIAN DETAILS:

First Name :

Last Name :

Email :

Mobile :

Address :

Relationship to child :

Medical History:

Please fill all the columns.

**Incomplete forms will not be processed.*

Heart Murmur/Problem	Y | N	Fainting	Y | N
Diabetes	Y | N	Bleeding Problem	Y | N
Epilepsy	Y | N	Asthma	Y | N
Dental Phobia	Y | N	Anaphylaxis	Y | N
Finger/Thumb Sucking	Y | N	Jaw or sleeping problem	Y | N
Autism	Y | N	Problems with previous dental treatment	Y | N

Does this child require Antibiotics. prior to Dental Treatmemnt? Yes No

Please list any allergies.

Please list any current medications.

Please list any medical conditions.

Medicare Consent and Dental Treatment Authorisation for Childern

- I have read and understood the Medicare Bulk Billing section of this form, including the safetyand benefits of the dental check-up and preventive care treatments as outlined at ***www.vmdh.com.au/treatment***. I have had an opportunity to ask questions and seek clarification on the information I have been provided by calling VMDH on **0483 102 562.**
- I understand that I **DO NOT** have to pay these costs and that they will be deducted from my child's **CDBS** Medicare balance.

I give consent for the following treatments to be done in the VMDH Van:

CHECKUP AND CLEAN
(88011,880111/880114)

sign here → *Date* / /

2 SMALL DENTAL X-RAYS
(88022)

sign here → *Date* / /

FISSURE SEALANTS up to 8 as required
(88161,88162)

sign here → *Date* / /

FLUORIDE APPLICATION
(88121)

sign here → *Date* / /

OR

TOOTH MOUSSE
Re-mineralising agent alternative to fluoride

sign here → *Date* / /

Sign the bulk-billing patient consent form to allow Victorian Mobile Dental Health to claim costs under Medicare

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.

NOTE: If the student does not have a Medicare card, please leave this section blank.

Medicare card number:

Individual reference number:

Expiry date:

Name of person signing (if not the patient)

Patient/legal guardian Signature

sign here →

Date

Do you consent for photos and/or videos of your child to be posted for marketing and/or promotional purposes (Photos taken by VMDH may be published to our website, social media, or other materials.) Yes No

** Incomplete forms will not be processed. Please fill all the columns.*