**PRIVACY STATEMENT**

Semper Dental respects your right to privacy and considers all of the information you have provided in this form to be personal information for the purposes of the Privacy Act 1988 as amended ("Privacy Act").

**Why Semper Dental collects your personal information?**

We collect your personal information primarily to enable us to provide dental care services to you in the most appropriate and efficient way. We may also use this information to promote health and related services to you or for other purposes permitted under the Privacy Act.

**How Semper Dental collects your personal information.**

1. Where possible we collect your personal information directly from you and where that is not reasonably practicable we may collect your personal information from other sources.
2. By sending these forms to you;
3. In addition, we may collect personal information from Related Persons or health service providers such as health insurers, government agencies, hospitals, doctors and medical specialists.

**How does Semper Dental use your personal information?**

We use your personal information in accordance with National Privacy Principles.

The personal information is used to:

1. Provide you with health and related services, including appointments and follow up services and
2. Promote the health-related products and services of Semper Dental.

**Your agreement**

By providing your personal information to us in this form or by other means you acknowledge and agree that Semper Dental may collect and use your personal information to provide health and related services to you;

**Medicare Charges**

88011- $57.65 Examination
88111- $58.90 Polish - Removal of plaque
88114- $98.20 Removal of calculus
88121- $37.85 Topical application of remineralisation and or Cariostatic agent.
88161- $50.45 Fissure Seals

**Non eligible families** **Note below**

$ 99.00 per child for all treatments plus
$ 46.00 per fissure seals

**( We will invoice you for these charges and once paid they may be eligible to be claimed against your private health insurance)**

**PLEASE ENSURE YOUR MEDICARE DETAILS ARE UP TO DATE WITH MEDICARE.**

**PLEASE CHECK THAT YOU HAVE COMPLETED ALL SECTIONS OF THIS FORM**

**OFFICE USE ONLY**

Eligible Y/N

| Practitioner: | Date Treated: |
| --- | --- |
| Dental assistant: | |

| 88011 | 88111 | 88114 | 88121 | 88161 |
| --- | --- | --- | --- | --- |
| | | | | |
| | | | | |

# Semper Dental

*"always looking after your oral hygiene"*

**FREE DENTAL CHECKUP AND TREATMENT FOR ALL ELIGIBLE STUDENTS AT ST SIMON THE APOSTLE PRIMARY SCHOOL**

Dear Parents and Carers

Commencing on Friday August 30th 2024 your child will have the opportunity to join the Semper Dental school dental program.

The treatment program is available to all participating students in school on the following basis:

1. Families who are in receipt of Family Tax Benefit Part A are eligible for the Medicare Child Dental Benefit Scheme Funding of up to $1,095 every two years. For additional CDBS details please visit: **https://www.humanservices.gov.au/individuals/services/medicare/child-dental-benefits-schedule.**

2. Families not in receipt of Family Tax Benefit Part A are offered a very generous fee for service treatment for $99.00. This covers the cost of an examination, scale and clean. Families with private health insurance are able to claim this cost against their private health cover with up to 3 item numbers making the out of pocket cost minimal. (see Pages 2 and 4 for additional information and payment options)

**The treatment program is offered in accordance with The Australian Dental Association recommendation that all primary school age children should see the dentist every six months. This is important to ensure that your child's teeth are well maintained, and six-monthly treatment will minimize the chance of decay.**

The services provided and the **convenience of being carried out at the school** makes it **easy for you** to have your child treated in this time and cost effective way. At each visit we provide a preventative treatment program. Preventative treatment involves an oral examination and treatment such as scale, cleaning, fluoride application and fissure seals where necessary. We will provide you with a report on each visit and will inform you if your child requires additional dental care.

If you wish to go ahead, please have the forms completed and returned to the school via reception or the class room by ,

**Friday August 23rd.**

**We recommend this program to you and your family.**

If you require any further information, please feel free to contact **Semper Dental** directly via email on

**annap@semperdental.com.au** or call **Anna on 0422 020 335**

Yours sincerely
**THE SEMPER DENTAL TEAM**

SEMPER DENTAL PTY LTD ABN 43 169 463 763
UNIT 44, 2 THOMSON'S ROAD KEILOR PARK, 3042 TEL 0422 020 335

**CONSENT FOR DENTAL TREATMENT BY SEMPER DENTAL AT ST SIMON THE APOSTLE PRIMARY SCHOOL**

Please ensure you complete and sign **ALL SECTIONS** of this form.

**PLEASE PRINT IN CAPITAL LETTERS**

Child first name:____________________________male/female (please circle one)

Child last name:________________________________________

Date of birth (DD/MM/YY)______________When did your child last visit a dentist? ________

Grade:________________Class:__________Teacher:________________

Address:______________________________________________

Parent/Guardian Name:______________________________________

Parent/Guardian contact number: __ __ __ __ __ __ __ __ __ __ (Please write carefully)

Parent/ Guardian email: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ (Please write carefully)

1. MEDICARE CARD NUMBER

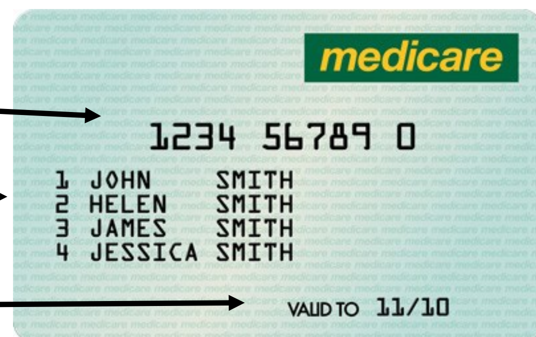
   ____ _____ _

2. CHILD INDIVIDUAL REFERENCE NUMBER

   _

3. EXPIRY DATE

   __/____




I give permission for Semper Dental to conduct a Medicare eligibility check for my child and for you to provide preventative treatment which may include oral examination, scale, clean and polish, removal of deposits (debris and stains) fluoride and fissure seals as required. ☐ (Please Tick)

**YOU MUST SIGN THIS DOCUMENT IN THE SPACE PROVIDED BELOW**

*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. 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.*

**I ________________________the parent / 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; (see over page) 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.**

**Patient's Medicare Number:** ____________________**Patient's Reference Number:** _______

**Patient's Full Name:** ____________________________

**Full Name of Person Signing:** ________________________*(please tick)*: ☐ **Parent** ☐ **Legal Guardian**

**Please sign here :** ____________________________

Please indicate if your child has EVER had any of the following: (please circle)

| Question | Y / N | Details |
|---|---|---|
| Are you receiving any medical treatment at present? If Yes provide details | Y / N | |
| Have you had any serious or long standing illness? If Yes provide detail | Y / N | |
| Have you been hospitalised? If Yes provide details | Y / N | |
| Are you taking any current medication? If Yes provide details | Y / N | |
| Allergies (e.g. latex, nuts, milk, lactose etc ) If Yes provide details | Y / N | |
| Do you need to discuss any relevant matters with your dentist prior to the commencement of any dental treatments. If Yes provide details | | |

| Condition | Y / N | Condition | Y / N |
|---|---|---|---|
| Asthma | Y / N | Kidney conditions | Y / N |
| Breathing difficulties / Bronchitis / lung disease | Y / N | Any Nervous system disorder | Y / N |
| Rheumatic fever or heart valve surgery | Y / N | High or low blood pressure | Y / N |
| Blood disorders/ bleeding disorders | Y / N | Hepatitis, jaundice or liver disease | Y / N |
| Epilepsy | Y / N | Treatment for any form of cancer | Y / N |
| Diabetes | Y / N | Transplanted organ or bone marrow | Y / N |
| Familia diseases | Y / N | Thyroid disease | Y / N |
| Infectious disease (measles, chicken pox) (Especially in the last 3 weeks) | Y / N | Tuberculosis | Y / N |
| Any heart complaint/treatment | Y / N | Any other medical information? If Yes provide details | Y / N |
| Does your child have any dental anxiety / ADHD— Please provide further information: | | | |

☐ I agree that the above is a true and accurate record of my child's medical history.

**If my child is ineligible for the Medicare Child Dental Benefits Scheme I agree to your offer to treat my child at a cost of $99.00 ( exam, clean and scale and fluoride).**

***If my child requires fissure seals I accept the charge is $46.00 per tooth. Please confirm Yes / No (circle)***

Card holders name ____________________

Card number __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiry date ___/___ CCV _ _ _

Signature ____________________

TICK IF YOU WOULD PREFER US TO INVOICE YOU ☐

TICK IF YOU REQUIRE A RECEIPT FOR YOUR HEALTH INSURANCE CLAIM ☐