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

- 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.
- By sending these forms to you.
- 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 the National Privacy Principles. The personal information is used to:

- Provide you with health and related services, including appointments and follow-up services; and
- 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.

FEE SCHEDULE

Medicare Item No.	Fee	Description	Non-eligible
88011	$60.95	Examination	**$115.00**
88111	$62.30	Polish – removal of plaque	
88114	$103.90	Removal of calculus	
88121	$40.05	Topical application of remineralisation and/or cariostatic agent	
88161	$53.35	Fissure seals	

Non-eligible families: $115.00 per child covers all the above treatments - We will invoice you for these charges, and once paid, they may be eligible to be claimed against your private health insurance.

OFFICE USE ONLY

Practitioner:		**Date Treated:**	
Dental Assistant:		**Eligible:**	☐ Y ☐ N

Tick item numbers performed at each visit:

	88011	88111	88114	88121	88161
Visit 1	☐	☐	☐	☐	☐
Visit 2	☐	☐	☐	☐	☐

Semper Dental

"always looking after your oral hygiene"

FREE DENTAL CHECKUP AND TREATMENT FOR ALL ELIGIBLE STUDENTS AT

Insert the name of your School:	

Dear Parents and Carers,

If you would like, your child will have the opportunity to join the Semper Dental school dental program.

Please complete this form and lodge with your child's classroom teacher or school reception as soon as possible.

The treatment program is available to all participating students in your child's school for up to two visits, subject to our agreement with the school:

- Families who are in receipt of Family Tax Benefit Part A are eligible for the Medicare Child Dental Benefit Scheme funding. For additional CDBS details please visit:

  https://www.humanservices.gov.au/individuals/services/medicare/child-dental-benefits-schedule

- Families not in receipt of Family Tax Benefit Part A are offered a very generous fee-for-service rate of $115.00 per child. This covers the cost of an examination, scale and clean. Families with private health insurance are able to claim this cost against their cover, with up to 3 item numbers, making the out-of-pocket cost minimal. (See additional information and payment options on the reverse of this document.)

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 minimises 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 a 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 proceed, please have the form completed and returned to the school via reception or the classroom as soon as possible.

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

SEMPER DENTAL PTY LTD ABN 43 169 463 763
Unit 44, 2 Thomson's Road, Keilor Park, 3042 | Tel: 0422 020 335

CONSENT FORM

School name:

Please ensure you complete and sign **ALL SECTIONS** of this form. **PLEASE PRINT IN CAPITAL LETTERS.**

CHILD / PATIENT DETAILS

Child first name:		**Sex:**	■ Male ☐ Female
Child last name:			
Date of birth (DD/MM/YY):		**Last dental visit:**	
Grade:		**Class / Teacher:**	
Address:			
Parent / Guardian name:			
Parent / Guardian contact number: *(please write carefully)*			
Parent / Guardian email: *(please write carefully)*			

MEDICAL HISTORY

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

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
Familial diseases	☐ Y ☐ N	Thyroid disease	☐ Y ☐ N
Infectious disease (measles, chicken pox) — esp. in last 3 weeks	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Any heart complaint or treatment	☐ Y ☐ N	Any other medical info? (If yes, provide details)	☐ Y ☐ N

OTHER MEDICAL QUESTIONS

Are you receiving any medical treatment at present? (If yes, provide details)	☐ Y ☐ N	
Have you had any serious or long-standing illness?	☐ 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)? (If yes, provide details)	☐ Y ☐ N	

Dental anxiety or ADHD — please provide further information:

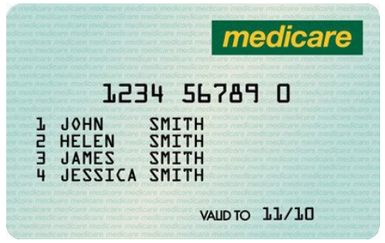
Anything else to discuss with the dentist before treatment? (If yes, provide details)

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

MEDICARE DETAILS

Fill in the boxes below. The arrows show where each number appears on your Medicare card.

Medicare card number (10 digits):	
Child individual reference number:	
Card expiry date (MM/YY):	



If your child is not eligible for the Medicare funding and you do not choose to pay (see below), then your child will not be seen by the Semper Dental team.

☐ **PERMISSION FOR ELIGIBILITY CHECK & PREVENTATIVE TREATMENT**

For every one of your visits, 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 the box above.)

YOU MUST SIGN THIS DOCUMENT BELOW

I understand that I / the patient will only have access to dental benefits up to the benefit cap.

I understand that benefits for some services may have restrictions, and that the 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 Schedule, and that costs of services will reduce the available benefit cap.

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 fee schedule on reverse); of the likely cost of this treatment; and that I will be bulk-billed for services under the Schedule and 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:		☐ **Parent** ☐ **Legal Guardian**
Signature:	**Date:**	

Australian Government
Department of Health

PAYMENT AUTHORITY (FOR NON-ELIGIBLE FAMILIES)

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 $115.00 (exam, clean, scale and fluoride). *This charge may be claimable if you have private dental insurance.*

PLEASE NOTE: This credit card / invoice authority covers BOTH Visit One ($115.00) AND Visit Two ($115.00) unless you opt out.

Cardholder name:	
Card number (16 digits):	
Expiry date (MM/YY):	CCV:
Signature:	

☐ **TICK IF YOU WOULD PREFER US TO INVOICE YOU AND/OR PROVIDE A RECEIPT FOR YOUR PAYMENT.**