FAQ's

Do I need to pay anything?

No, Medicare CDBS covers these costs for eligible students via Bulk Billing.

If your child is not eligible, ADHV will do a **FREE** Dental Health Screen and tooth strengthening remineralisation.

Do I need to attend?

No, our experienced dental team will ensure your child is looked after.

If you would like to attend or have any questions, please contact our office.
(03) 9323 9607

CONSENT FORM QUESTIONNAIRE

Please circle your answers below

How often does your child brush their teeth with toothpaste?

Once daily 2 times daily
Rarely Unsure

When did your child last visit a dental professional?

Less than 12 months
More than 12 months
Never Unsure

How often does your child normally drink water?

Once a day
More than once a day
Rarely Unsure

How often does your child consume sugary food or drink?

Every day
Sometimes within a week
Rarely Unsure

GUIDE TO MEDICARE BULK BILLING

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 ADHV. For more information regarding CDBS, please visit www.humanservices.gov.au/childdental

ADHV 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.

ZERO out of pocket cost to you

ITEM	SERVICE	CDBS BULK BILL FEE	YOUR OUT OF POCKET COSTS
88011	Comprehensive Oral Examination	$56.40	$0.00
88012	Periodic Oral Examination	$47.90	$0.00
88013	Limited Oral Examination	$30.10	$0.00
88111	Removal of Plaque / Stain	$58.90	$0.00
88114	Removal of Calculus – 1st visit	$98.20	$0.00
88115	Removal of Calculus – 2nd visit	$63.85	$0.00
88121	Topical Remineralisation agents	$37.85	$0.00
88022	Periapical or Bitewing X-ray	$33.35 ea	$0.00
88161	Tooth Surface/Fissure sealing (first 4)	$50.45 ea	$0.00
88162	Tooth Surface/Fissure sealing (Additional services)	$25.25 ea	$0.00

Please visit www.adhv.com.au/dentaltreatment for details of what each treatment involves.

Please visit www.adhv.com.au/privacy to view our Privacy Policy.

If you have any questions, please contact (03) 9323 9607.

School Dental Initiative

1 FILL IN FORM

The dental health van is visiting our school to actively find and prevent dental decay early!

Please fill and return this form to school.

2 THE VISIT

Students can receive a full check-up, preventative and general dental care at school.

If your child needs further treatment, you will be called for consent.

3 NO OUT OF POCKET COSTS

The ADH Dental Initiative is funded by Australian Dental Health and the Child Dental Benefits Schedule.

If your child is not Medicare eligible, ADHV will provide a **FREE** Dental Health Screening and tooth strengthening fluoride remineralisation.

Health - Education - Community

(03) 9323 9607 info@adhv.com.au www.adhv.com.au 2/3 Astralia Place HALLAM VIC 3805

MEDICAL HISTORY & CONSENT

PLEASE USE CAPITAL LETTERS

Child's First Name:

Child's Middle Name:

Child's Last Name:

Date of Birth: / /

School Name:

School Campus: (If applicable)

Year Level: Form Group:

Parent/guardian name:

Email:

Mobile:

Parent/guardian Address:

Has this child had dental X-rays in the past 6 months please tick here. Yes No

PLEASE CIRCLE YES/NO TO ANY OF THE FOLLOWING

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

Does this child require Antibiotics prior to Dental Treatment? Yes No

Please list any allergies.

Please list any current medications.

Please list any other medical conditions.

1. Medicare Consent and Dental Treatment Authorization for Children

- I have read and understood the Medicare Bulk Billing section of this form, including the safety and benefits of the dental check-up and preventive care treatments as outlined at www.adhnsw.com.au/dentaltreatment. **I have had an opportunity to ask questions and seek clarification on the information I have been provided by calling ADHV on (02) 9323 9607**
- 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 to ADHV to provide dental treatment to my child including a dental examination. If my child requires a clean or remineralisation for their teeth I give further consent.**
- **If my child is not Medicare eligible, I understand ADHV will provide a free dental health screening and tooth strengthening fluoride remineralisation.**

If you have anything to note, or do not consent to specific treatment, please specify. _____

_____

_____

Parent/Guardian
SIGNATURE
REQUIRED

Date / /

2. Small Dental X-rays: significantly increase the detection of tooth decay and are safe for people of all ages.I give consent to take up to 2 small dental x-rays for diagnosis if they are required.

Parent/Guardian
SIGNATURE
REQUIRED

Date / /

3. Fissure Sealants: As well as consenting to the above, I also consent to place seals on my childs teeth (molars) if they are required (up to 8 seals).

Parent/Guardian
SIGNATURE
REQUIRED

Date / /

PLEASE SIGN ALL SECTIONS SEPARATELY

Australian Government
Department of Health

CHILD DENTAL BENEFITS SCHEDULE
BULK BILLING PATIENT CONSENT FORM

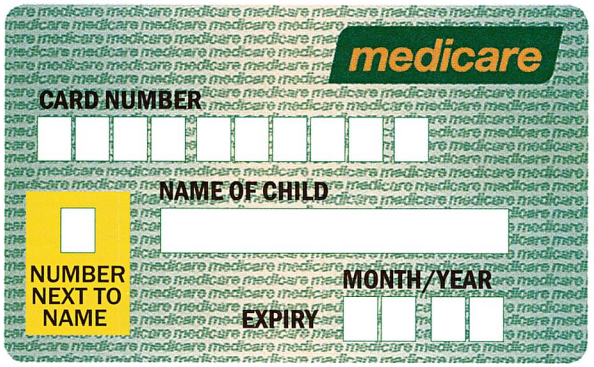
I, the patient / legal guardian, certify that I have been informed:

- 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.



***ADHV will not charge** any out of pocket costs for services completed.

PLEASE FILL ALL DETAILS

_____
Full Name of person signing (if not the patient)

_____
Patient/legal guardian Signature

SIGNATURE

Date _____/_____/_____

This form is valid up to 31 December of the calendar year for which it is signed