



## White Cross Mobile Dental Care







**Did you know?** Children with poor oral health were nearly **3 times more likely to miss school** due to dental pain. Tooth decay is the most common childhood disease, five times more common than asthma and 3 out of every 5 children are infected by tooth decay.

It is essential for children to have regular dental check-ups as tooth decay can be entirely preventable, educating good oral hygiene will eliminate pain and prevent major problems in the future.



White Cross Mobile Dental Care will provide all children with a **free** comprehensive examination checking all teeth and gums.

All Students will receive all the procedures listed below only if **necessary**, with no out of pocket costs.

<b>Examination:</b> Each child's appointment with the Dental Hygienist 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 any tooth decay and other potential problems which may impact on your child's health.	
<b>Scale / Clean / Polish:</b> Dental cleanings involve removing plaque (soft, sticky, bacteria infested film) and tartar (calculus) deposits that have built up on the teeth over time. The purpose of the cleaning and polishing is basically to leave the surfaces of the teeth clean and smooth so that bacteria are unable to stick to them and you have a better chance of keeping them healthy and avoiding tooth decay.	<div><div><i>Before</i></div><div><i>After</i></div></div>
<b>Fluoride:</b> 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 repair the early stages of tooth decay.	
<b>Fissure Sealants:</b> Fissure sealants are a safe and painless way of protecting your child's teeth from tooth decay. It is a plastic coating which covers the chewing surface of the back adult teeth. The <b>sealant</b> forms a hard shield that keeps food and bacteria getting into the tiny grooves in the teeth.	<div></div>

Our professional team of Dental Hygienist understand it can be overwhelming for children to have a dental examination, but we have strategies in place and we will endeavour to provide a comfortable and positive dental experience.

Your child will receive an assessment letter outlining their treatment provided and any further treatment required to follow up with your preferred or local dentist.

If you are happy with your child to be seen by our Dental Hygienist, please complete the Medicare Consent and the Patient Medical History forms attached.

If you have any questions regarding your child's treatment, please do not hesitate to contact our office on **(02) 9890 9299** or email us at: [whitecrossmobiledentalcare@gmail.com](mailto:whitecrossmobiledentalcare@gmail.com)



# White Cross Mobile Dental Care

Dear Parent / Guardian

\_\_\_\_\_ had an oral examination on \_\_\_\_\_

***The following treatment was provided:***

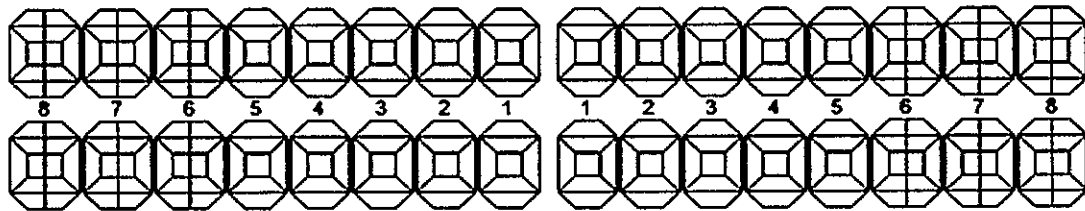
Examination (Teeth & Gums) ☐  
Scale / Clean / Polish ☐  
Fissure Sealants ☐  
Fluoride ☐

***The following diagnosis is:***

Oral Hygiene:

Poor ☐ Fair ☐ Good ☐

Tooth Decay / Work to be carried out:



Notes:

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***Please present this letter to your preferred or local dentist for follow up treatment.***

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

Chang Hoo Park  
Dental Therapist/Hygienist



White Cross Mobile Dental Care  
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Email: whitecrossmobiledentalcare@gmail.com

Shop 2/411 Church Street  
Ph: 02 9890 9299



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.*

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient / Legal guardian signature

\_\_\_\_\_/\_\_\_\_\_  
Patient's Medicare Number

\_\_\_\_\_  
Full name of person signing

\_\_\_\_\_/\_\_\_\_\_  
Number on card Valid to

\_\_\_\_\_  
Guardian Contact No

\_\_\_\_\_  
Date



## Child Health / Dental History Form

Patient Name:	Year/Class
Last:	First:
Date of Birth:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Parent's / Guardian's Name	
Contact No:	

## Medical History

Has the child had any history of, or conditions related to, any of the following;

	Yes	No		Yes	No
Allergy Latex	<input type="checkbox"/>	<input type="checkbox"/>	Allergy Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Fainting / Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Radiotherapy / Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Anaesthetic Problems	<input type="checkbox"/>	<input type="checkbox"/>

List all medications: \_\_\_\_\_

Allergies: (other) \_\_\_\_\_

**How does your child feel about having a dental examination?**

Extremely Nervous ☐ Moderate Nervous ☐  
Mild case of nerves ☐ Relaxed and confident ☐

**How long is it since your child had seen a dentist?**

More than 6 Months YES ☐ NO ☐

