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- $53.35 Examination
88111- $54.50 Polish
88114- $90.85 Scale and Clean
88121 $35.00 Fluoride
88161- $46.65 Fissure Seals

Non eligible families

$ 99.00 per child for all treatments plus
$ 44.00 per fissure seals
(these charges may be eligible to be claimed 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

1st visit

Dentist:			Date Treated:	
Dental assistant:				
88011	88111	88114	88121	88161

2nd visit

Dentist:			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 Parent/Guardian

Commencing on June 7, 2021 your child will have the opportunity to join the Semper Dental 2021 school dental program.

If due to COVID19 your child has not recently seen a dentist we would encourage you to take up this offer.

The bi annual treatment program is available to all participating students in school terms two and four 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 $1,000 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 Page 3 for additional information and payment options)

The twice yearly 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 and therefore we operate a twice yearly preventative treatment program at your child's school. 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 MAY 28, 2021**

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 **mac@semperdental.com.au** or call **Mac** on 0412 077 067

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 0412077067

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? _________

Class:_________________Grade:_________________Teacher:______________________

Address:____

Parent/Guardian Name:____

Parent/Guardian contact number:____

Parent/ Guardian email ____

1. MEDICARE CARD NUMBER

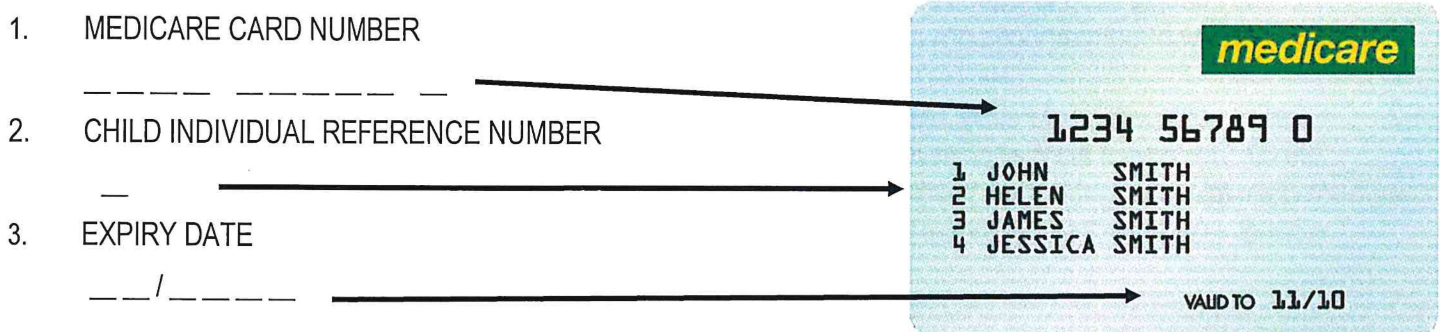
   _ _ _ _ _ _ _ _ _ _

2. CHILD INDIVIDUAL REFERENCE NUMBER

   _

3. EXPIRY DATE

   _ _/_ _ _ _



☐ (please Tick)

I give permission for Semper Dental to conduct a Medicare eligibility check for my child and for preventative treatment which may include oral examination, scale, clean and polish, removal of deposits (debris and stains) fluoride and fissure seals as re-quired. I further understand that you will return to the school for the second visit in term 4 and you will provide me with dates and an opt out option at this time.

If your child is not eligible for the Medicare funding, please see next page for payment options.

PLEASE PROVIDE CHILD'S DETAILS OR DISCUSS THEM WITH YOUR DENTIST.

INFORMATION ABOUT YOUR CHILD'S MEDICAL HISTORY IS FOR YOUR DENTIST'S USE ONLY

Past/ current medical conditions (please circle)

Are you receiving any medical treatment at present? Y/N Details______________________________

Have you had any serious or long standing illness? Y/N ______________________________

Have you been hospitalised? ____

Details if yes to any of the above ____

Are your child's immunisations up to date? Y/N Current medications___________________________

Allergies (e.g. latex, penicillin, etc)____

Do you need to discuss any relevant matters with your dentist prior to the commencement of any dental treatments. Y/N

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

Any heart complaint/treatment	Y/N	kidney conditions	Y/N
Rheumatic fever or heart valve surgery	Y/N	Any Nervous system disorder	Y/N
High or low blood pressure	Y/N	Asthma / bronchitis / lung disorders	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 other medical information?	Y/N		

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

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 : ________________________________

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.

This charge may be claimable if you have private dental insurance.

Card holders name ______________________________-

Card number _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Expiry date ___/___ CCV _ _ _

Signature ____________________

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