

## 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.

### 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](http://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 - 1 <sup>st</sup> visit	\$98.20	\$0.00
88115	Removal of Calculus - 2 <sup>nd</sup> 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/dental/treatment](http://www.adhv.com.au/dental/treatment) for details of what each treatment involves.

Please visit [www.adhv.com.au/privacy](http://www.adhv.com.au/privacy) to view our Privacy Policy.

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



# FREE\* Dental at Our School

Fill in this form and return to our school ASAP



### Convenient and Fear Free

#### Free\*, accessible and convenient.

The service can provide Dental Health Screens, checkups, cleans and preventative and general dental care at school in a fully functional dental truck - just like a dental clinic.

No more wasted time to find and book a dentist. Less time off work for you and more time in school to learn for them.



### Catch and Fix Early

**No one wants a toothache, missing teeth or gum disease. Brushing daily is not enough!** Regular professional checks find anything hiding that you cannot. We aim to find, prevent and treat dental issues early, keeping teeth healthy and in great shape.



### A Lifetime of Healthy Smiles

**Its our duty to create good oral health habits.** Desensitising students to healthcare professionals at a young age is a great way to give them life long health habits growing up. The best place for this to happen is in a familiar and comfortable environment at School.



### Free Dental\* Explained - No Out Of Pocket Costs

The Dental Service is funded by Australian Dental Health Victoria and the Medicare Child Dental Benefits Schedule (CDBS). The Australian Government determines the eligibility criteria for CDBS. You do not pay for this service and we will check the eligibility for you.

- **Medicare CDBS eligible:** No out-of-pocket costs for dental treatments.
- **Not CDBS eligible:** ADHV will self-fund a FREE Dental Health Screening.

## Please Hand to Every Student

The Trusted Dental Service by Victorian Schools Since 2014.

# 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 Authorisation 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.adhv.com.au/dental/treatment](http://www.adhv.com.au/dental/treatment). **I have had an opportunity to ask questions and seek clarification on the information I have been provided by calling ADHV on (03) 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 Comprehensive dental examination (Item 88011). If my child requires a clean (Item 88111 or 88114) and/or remineralisation (Item 88121) for their teeth, I give further consent.**
- If my child is not Medicare eligible, I understand ADHV will provide a free dental health screening.**

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

Parent/Guardian

**SIGNATURE** ➡

REQUIRED

 /  / 

Date

Parent/Guardian

**SIGNATURE** ➡

REQUIRED

**2. Small Dental X-rays (Item 88022):** 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.

 /  / 

Date

Parent/Guardian

**SIGNATURE** ➡

REQUIRED

**3. Fissure Sealants (Item 88161 & 88162):** As well as consenting to the above, I also consent to place seals on my child's teeth (molars) if they are required (up to 8 seals).

 /  / 

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**

**medicare**

**CARD NUMBER**

**NAME OF CHILD**

**NUMBER NEXT TO NAME**  **MONTH/YEAR**

**EXPIRY**

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