Novita Dental Program

Dental Practice QIP Quality Innovation Performance ACCREDITED

Dear Parent/Guardian,

Thank you for your interest in the Novita Dental Program, in partnership with Grow Up Smiling.

To take part in our program, please complete the following attached forms:

1. Patient Details & Medical History
2. Patient Information & Consent
3. Child Dental Benefits Schedule (CDBS) Bulk Billing Patient Consent

Once finished, please send all three forms to Grow Up Smiling using one of the following methods:

- Emailed to gus@growingupsmiling.com.au
- Faxed to (08) 82672013
- Hand Delivered to your local Novita site which will then be forwarded to Grow Up Smiling.

If you have any further questions about the program, please contact Grow Up Smiling on (08) 7226 1709 or Novita on 1300 668 482.

Patient Details & Medical History

Site/Clinic Location

A. Patient Details

Full name of Patient (Student - as shown on Medicare Card)

Preferred Name

Date of Birth

Student's Gender ☐ Male ☐ Female

Address

B. To be completed by Parent or Guardian where Patient is younger than 16

Parent / Guardian Full Name

Phone Number

Mobile Phone Number

Email

Address

Emergency Contact Name & Phone

Does the Patient have (or have they had) any of the following conditions? Please tick Yes or No

Heart trouble of any kind	☐ Yes	☐ No	Bleeding or Blood Disorders	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
HIV (AIDS)	☐ Yes	☐ No	Allergic to Penicillin	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Hepatitis A B or C (please specify)	☐ Yes	☐ No
Women: Are you pregnant	☐ Yes	☐ No			
Any known allergies	☐ Yes	☐ No	Please detail		
Currently taking any medication	☐ Yes	☐ No	Please detail		

Any other serious illnesses, adverse reactions to prior dental treatment or any other comments you'd like to make ☐ Yes ☐ No

If yes, please detail here (and overleaf if necessary)

When was the last time your child saw a dentist?

I, _____ **confirm that the above information is up to date and correct**

(Insert your name)

Signed ..... **Date** ..... /..... /.....

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Patient Information & Consent

Medicare Card/Health Insurance Details

Patient's Medicare Card

1. Card Number

				-						-	

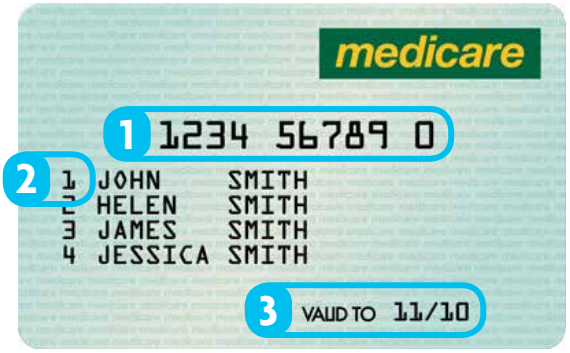
2. Reference Number

3. Valid To

		-		

Note: An example card has been provided to guide you as to where you can find the above information (refer image to right). Refer to your own card to find the following information:

1. Medicare Card Number (eg: '1234 56789 0')
2. Reference Number (eg: '1')
3. Valid to (eg: '11/10')



Health Insurance Details

Does the patient have any Private Health Insurance (dental cover)

☐ No ☐ Yes (if yes please detail below)

Health Fund Provider Name:

Confirmation

I, _____ confirm I am the ☐ Father ☐ Mother ☐ Legal Guardian ☐ Student (if over 16)

(Insert your name)

of, _____ and hereby consent to a dental exam by Dental Outreach's GuS Program

(Insert your child's name)

in addition to the following services ☐ **x-rays** ☐ **fluoride** ☐ **teeth cleaning**

(Please tick what you consent to)

Signed ..... **Date** ..... /..... /.....

If any further treatment is required, we will contact you to discuss the options available and obtain consent prior to performing any additional treatment.

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 Medicare number

_____
Patient / legal guardian signature

_____
Patient's full name

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

_____
Date

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