Murri School Van

Dear Parent/Guardian

Atsichs Brisbane would like to invite your enrolled child to be seen at the Atsichs- Murri School Dental Van.

ATSICHS dental staff will continue to be committed to the importance of your child's oral health with being available at the school all year-round including school holidays.

Healthy teeth and gums are important for our smiles but also for our general health.
Regular Dental visits are important to your child's oral health. Early prevention ensures healthier mouths throughout your child's life. Regular check up's help prevent cavities and tooth decay which then may lead on pain or toothaches.

If you are happy for your child to be seen at the Murri School Dental Van, please ensure the following forms are completed and handed back to the school office as soon as possible.

With the school's collaboration and consent forms completed, we can see your child at our dental van without a parent/guardian present. Once consent forms have been received our team will make an appointment for your child. A notification of appointment time/date will be sent to the contact number supplied. Your child will also receive a communication slip at the end of each appointment with the service details that have occurred and future appointments.
If you wish for your child to not be seen without a parent/guardian present, please ensure you complete the consent below and our team will be in touch with an appointment.

Following the initial appointment ATSICHS Dental Van staff will continue any further treatment your child may need, and your child will be scheduled into the Dental Van for any ongoing oral health care/treatment.

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Please tick:

☐ I consent to ATSICHS Dental staff to see my child without a parent/guardian present.

☐ I **do not** consent to ATSICHS Dental Staff to see my child unless a parent/guardian is present.

Please fill in all details or ask reception for help if you didn't understand any of the questions.

Last name:	First Name:
Date Of Birth: / /	Gender: ☐ F ☐ Non-specified ☐
Home Address:	Home Number: ( ) Work Number : ( ) Mobile Number:
Medical practitioner name: Phone: ( ) Surgery address:	Emergency contact person: Phone: ( )
Are you a regular ongoing client of one of our ATSICHS Medical Clinic's: **Y** ☐ or **N** ☐	If Yes please circle which one: **W' Gabba, Logan, Logan Lea, Northgate or Browns Plains.**

Please circle:
Do you recognise yourself as *Aboriginal* or *Torres Strait Islander* or *Both* or *Neither* or *Spouse?*

Medicare Card Number with Position: _____(___)_____ **EXPIRY**: ___/_____

Please Turn Over Page

Do you have a ***Centrelink Concession Card?*** **Type:** _____ **CRN number:** _____ **EXPIRY:** ____ / ___ /_____

Private Health Fund (name) _____

Do you smoke? ☐ *YES* or *NO* ☐ Quantity: _____ /day

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?
(Please tick all appropriate box(es) **Y** = *Yes* **N** = *No*

	Y	N		Y	N		Y	N
Any heart disorder	☐	☐	Stroke	☐	☐	Kidney Disease	☐	☐
High or Low blood pressure	☐	☐	Asthma	☐	☐	Diabetes	☐	☐
Heart valve disorder, eg Murmur	☐	☐	Bronchitis or other lung diseases	☐	☐	Stomach or digestive problem	☐	☐
Rheumatic Fever	☐	☐	Tuberculosis	☐	☐	Epilepsy/Seizure	☐	☐
Cardiac pacemaker	☐	☐	Thyroid disease	☐	☐	Cancer/Cancer Treatment	☐	☐
Prosthetic or other implant eg Shunt	☐	☐	Steroid/cortisone therapy	☐	☐	Head and Neck Radiation Therapy	☐	☐
Excessive bleeding	☐	☐	Growth disorder	☐	☐	Contact with HIV/AIDS virus	☐	☐
Anaemia, leukaemia, or other blood disease.	☐	☐	Systematic Lupus Erythromatosis (SLE)	☐	☐	Hepatitis A, B,C or other liver diseases (Please specify)_____	☐	☐
Osteoporosis, arthritis or any bone disorder	☐	☐	Are you pregnant? (Female only) Baby due:	☐	☐	Have you ever had a broken jaw?	☐	☐
Mental/ Behavioural conditions	☐	☐	Do you normally require antibiotic cover before dental treatment?				☐	☐

Other illness or disabilities:

Current medical treatment:

Names of medication you are currently taking:

Do you have any abnormal reactions to any medications? (e.g. Penicillin, Local Anaesthetic or others)

Please list any other know allergies: (e.g., Latex)

Do you require any interpreter services for your appointment? ☐ YES / NO ☐

PLEASE LIST ALL THE CONCERNS YOU HAVE WITH YOUR TEETH OR MOUTH:

_____

_____

_____

To be eligible for appointments at our dental clinics you must:

- reside in SE Qld and identify as Aboriginal or Torres Strait Islander
- be a regular ongoing patient with one of our ATSICHS medical clinics.
- speak to our reception staff if you are a non-indigenous patient with an indigenous spouse as you may be eligible for care

Is the child in care arrangements such as Kinship/Foster Care or Child Safety Authority?
If yes, please supply further information.
Authoritative Guardian Name and Contact Number: _____

(Office use only)

I give consent for Examination, Professional Scaling of the Teeth, Bitewing Radiographs, Fluoride treatment/Silver Fluoride treatment *(Possible Staining of Teeth)* and treatment of dental conditions for the following: fissure sealants and fillings.

If your child requires further dental treatment (such as crowns or extractions) how would you prefer to be contacted? Please Tick your preference

Letter ☐ ***Phone call*** ☐ ***SMS*** ☐

(Parent/ Guardian to sign if patient is under 18 years old)]

Signature: _____ Date: _____

Contact Number: _____

Parent/Guardian Name: _____

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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

Reference No. ☐

Full name of person signing
(if not the patient)

Patient's full name

Date

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