CC's DENTAL SURGERY
CATE CORCORAN GILGANDRA

CCs Dental Surgery Preventative Dental Care Screening.

Cate and her Team from CCS Dental Surgery will be visiting Gilgandra Public School this term!

Oral Health is an important part of a child's development and wellbeing. Oral health problems that aren't diagnosed or treated can cause pain and can interfere with a child's ability to eat, sleep, play and function at home and School.

Preventative dental care will reduce the risk of cavities, gum disease and other dental issues. Improving a child's oral health requires practicing a good oral hygiene routine and regular dental visits.

CCs Dental screening aims to provide Gilgandra public school students with

- a comprehensive examination
- checking all teeth and gums
- hand scale/ clean and polish
- fluoride application

This visit will also be a great opportunity to assess, educate and provide preventative dental treatment to all students in a comfortable environment.

Parent information packs and consent forms have been handed out today. Please complete and return to the school ASAP so your child can be a part of this screening.

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Child Oral Health Screening. School Assessment Consent form.

Child's details – one form per child. Please circle & fill all boxes.

Please check my child's teeth at school: **YES** **NO**

Child's School: Gilgandra Public School

Year:_____

Class:_____

Gender: _____

Date of Birth:_____

Address:_____

Postcode:_____

Phone/Contact Numbers Home:_____

Mobile:_____

Work:_____

Does your child have any medical conditions? **YES** **NO**

If yes, please list below.

_____

Does your child have any allergies? **YES** **NO**

If yes, please list below:

_____

Is your child currently taking any prescription medication? **YES** **NO**

If yes, please list below:

_____

Parent/Guardian Name:_____

Signature:_____ Date:_____

Please complete and return to the school before screening day.

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.