

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.

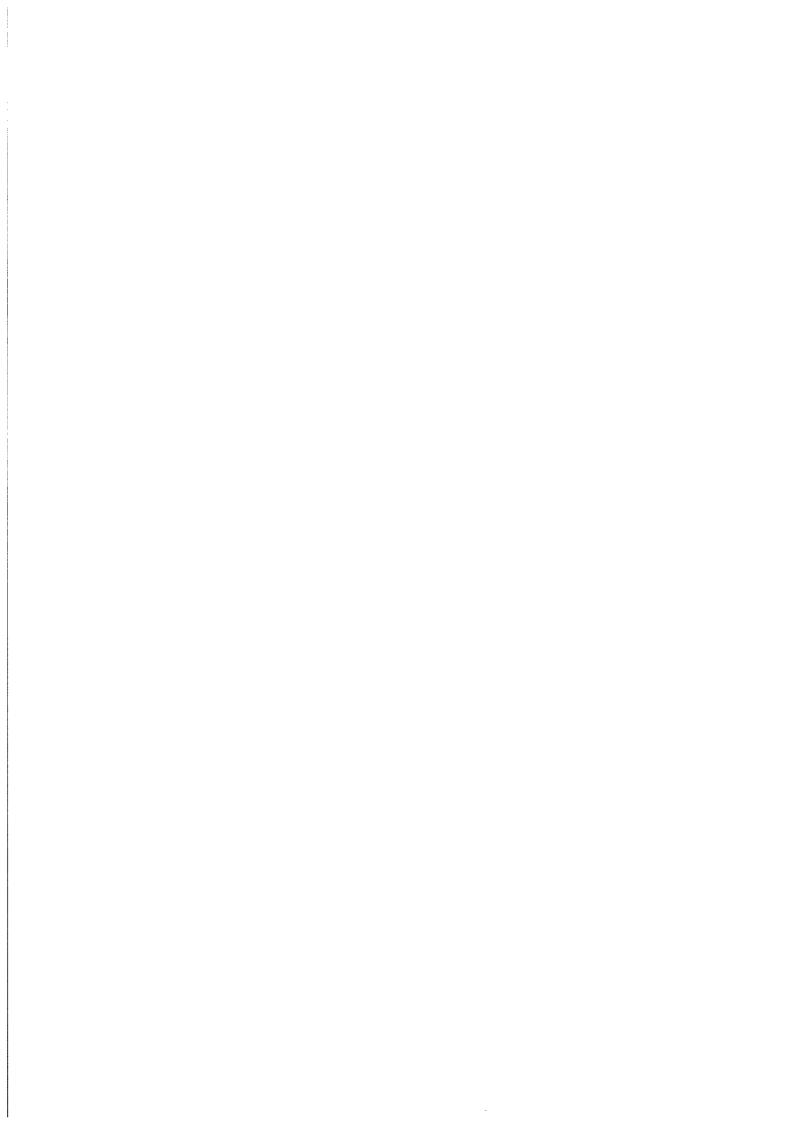
Preventative dental care will reduce the risk of cavities, gum disease and other dental issues. Improving a child's oral health requires practicing a good oral hygiene routine and regular dental visits.

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.





<u>Child Oral Health Screening. School Assessment Consent form.</u> <u>Child's details – one form per child. Please circle & fill all boxes.</u>

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: Dat	e:	



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

Patient's full name

• 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

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.