

## HIGH - END DENTAL TREATMENT. ANYTIME, EVERYWHERE.

Globe Mobile Dental Services provides a free mobile dental service under the Medicare Child Dental Benefits Scheme for children aged 2-17 years. We provide children with essential dental treatment & education using the latest technology in portable dental units.

Our program involves:

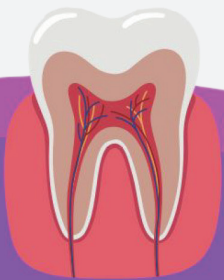
- Dental education about oral hygiene and the importance of maintaining great oral health.
- Comprehensive oral examination.
- Scale, polish and clean.
- Tooth mousse (topical application for prevention of decay).
- Fissure Sealant (if required).

### Did you know?

Children with poorer oral health status were more likely to experience dental pain, miss school, and perform poorly in school. These findings suggest that improving children's oral health status may be a vehicle to enhancing their educational experience.

### When to see a dentist?

All children should visit the dentist regularly (every six to 12 months) for a check-up, even if they don't appear to have any problems. Visiting the dentist regularly can help prevention, early detection, and management of tooth decay.



#### MORE INFORMATION:

 [info@gmdclinics.com.au](mailto:info@gmdclinics.com.au)

 0287588657

 [www.gmdclinics.com](http://www.gmdclinics.com)

**GMD  
CLINICS**



**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.*

Child full name : \_\_\_\_\_

Child date of birth: \_\_\_\_\_

1 Child Medicare card number : \_\_\_\_\_

2 Child's individual reference number: \_\_\_\_\_

3 Expiry Date : \_\_\_\_\_

School/preschool name : \_\_\_\_\_

Class: \_\_\_\_\_

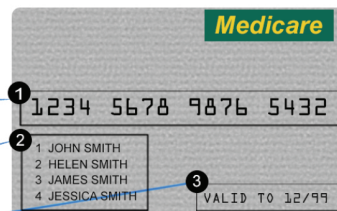
Patient / legal guardian signature : \_\_\_\_\_

Full name of person signing (if not the patient) : \_\_\_\_\_

Guardian Contact Number : \_\_\_\_\_

Guardian Email: \_\_\_\_\_

Date: \_\_\_\_\_



When did your child last visit a dentist ? \_\_\_\_\_

Please provide details or discuss them with your dentist. Information about your medical history is for your dentist's use only.

|   |       |         |
|---|-------|---------|
| Past/Current medical conditions                     |       |         |
| Are you receiving any medical treatment at present? | Y / N | Details |
| Have you had any serious or long standing illness?  | Y / N | Details |
| Have you ever been hospitalised?                    | Y / N | Details |

Please indicate if you have EVER had any of the following:

|  |       |                                      |       |
|--|-------|--------------------------------------|-------|
| Any heart complaint/treatment  | Y / N | Any nervous system disorder          | Y / N |
| Rheumatic fever or heart valve surgery                                       | Y / N | Asthma/bronchitis/lung conditions    | Y / N |
| High or low blood pressure   | Y / N | Radiation therapy / chemotherapy     | Y / N |
| Blood disorders / bleeding disorders   | Y / N | Thyroid disease                      | Y / N |
| Epilepsy   | Y / N | Hepatitis, jaundice or liver disease | Y / N |
| Diabetes   | Y / N | Treatment for any form of cancer     | Y / N |
| Familial diseases  | Y / N | Transplanted organ or bone marrow    | Y / N |
| Infectious disease (measles/chicken pox), especially in the last three weeks | Y / N | Kidney conditions                    | Y / N |
| Tuberculosis   | Y / N | Other                                | Y / N |
| Details if yes to any of the above:  |       |                                      |       |

|  |       |                     |  |
|--|-------|---------------------|--|
| Are your child's immunisations up to date? | Y / N | Current medications |  |
| Allergies (e.g. latex, penicillin, etc):   |       |                     |  |

[ ] If eligible, please provide oral examination/clean/scale/fissure seals if required.

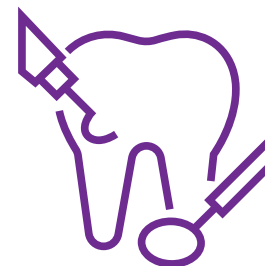
I agree that the above is a true and accurate record. Should you wish to discuss any relevant matters with your dentist prior to commencement of any dental treatments please call us on **02 8758 8657**

Signature : \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

### Why choose GMD Clinics?

We believe that you deserve to smile at every stage of life. To achieve this, we make it our goal to partner and journey with you towards a beautiful smile, always. Together, we can overcome the barriers that may come with accessing quality, affordable dental care and ensure that your Oral health is always at its best.



**We're Mobile for Your Smile!**



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