Tuesday, 11 June 2019

White Cross Mobile Dental Care

Dear Parent(s)/Carer(s),

White Cross Mobile Dental Care have offered their services to children across the school and will be coming to the school in Term 3. They will be at the school from Monday, 29 July until Friday, 9 August (Term 3, Weeks 2 and 3). They will be providing comprehensive examinations to check student's teeth and gums. The service is free to all students for the examination and parents are asked for Medicare Consent if further work is to be carried out after being examined. Medicare card details will need to be provided so that the consultation can be bulk billed.

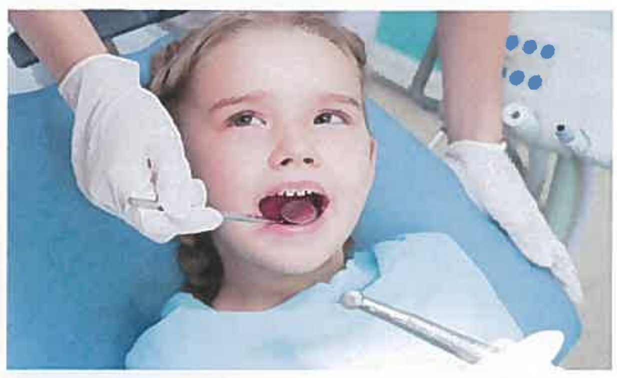
The only work that will be carried out by the mobile dental van is examination, dental cleaning, fluoride use and fissure sealants. Children that are seen will be provided with an assessment outlining their treatment that has been provided. Any other dental needs will be shared with you in writing so that you can book an appointment for your child with his/her local dentist or the free Community Health Dental Service in Pambula. If you have any questions about the service, you can contact White Cross Mobile Dental Care on (02) 9890 9299.

Regards

Brenton Mace
Assistant Principal Special Education

PO Box 48
Merimbula NSW 2548
Ph: 64951266 FAX: 64953239
merimbula-p.school@det.nsw.edu.au

White Cross Mobile Dental Care



Did you know? Children with poor oral health were nearly **3 times more likely to miss school** due to dental pain. Tooth decay is the most common childhood disease, five times more common than asthma and 3 out of every 5 children are infected by tooth decay.

It is essential for children to have regular dental check-ups as tooth decay can be entirely preventable, educating good oral hygiene will eliminate pain and prevent major problems in the future.

White Cross Mobile Dental Care will provide all children with a comprehensive examination checking all teeth and gums.

All Students will receive all the procedures listed below only if ***necessary***, with no out of pocket costs.

Examination: Each child's appointment with the Dental Hygienist will involve a thorough soft tissue examination and assessment of your child's teeth and gums by using a small mirror and explorer. This is to check for any tooth decay and other potential problems which may impact on your child's health.	
Scale / Clean / Polish: Dental cleanings involve removing plaque (soft, sticky, bacteria infested film) and tartar (calculus) deposits that have built up on the teeth over time. The purpose of the cleaning and polishing is basically to leave the surfaces of the of the teeth clean and smooth so that bacteria are unable to stick to them and you have a better chance of keeping them healthy and avoiding tooth decay.	Before After
Fluoride: Fluoride is a mineral that helps strengthen your teeth and also can prevent tooth decay by making the tooth resistant to acid attacks from plaque, bacteria and sugars in the mouth. Fluoride may reduce cavities and help repair the early stages of tooth decay.	
Fissure Sealants: Fissure sealants are a safe and painless way of protecting your child's teeth from tooth decay. It is a plastic coating which covers the chewing surface of the back adult teeth. The ***sealant*** forms a hard shield that keeps food and bacteria getting into the tiny grooves in the teeth.	Prior to Sealing After Sealing

Our professional team of Oral HealthTherapist understand it can be overwhelming for children to have a dental examination, but we have strategies in place and we will endeavour to provide a comfortable and positive dental experience.

Your child will receive an assessment letter outlining their treatment provided and any further treatment required to follow up with your preferred or local dentist.

If you are happy with your child to be seen by our Oral Health Therapist, please complete the Medicare Consent and the Patient Medical History forms attached.

If you have any questions regarding your child's treatment, please do not hesitate to contact our office on **(0414 570 785)** or email us at: whitecrossmobiledentalcare@gmail.com

White Cross Mobile Dental Care

Dear Parent / Guardian

______________________________ had an oral examination on _______________________

The following treatment was provided:

- Examination (Teeth & Gums) ☐
- Scale / Clean / Polish ☐
- Fluoride ☐
- Fissure Sealants ☐
- Temporary Filling ☐

The following diagnosis is:

Oral Hygiene:

Poor ☐ Fair ☐ Good ☐

Tooth Decay / Work to be carried out:

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

Notes:

____

____

____

Please present this letter to your preferred or local dentist for follow up treatment.

If you have any further enquires please don't hesitate to call or email.

Chang Hoo Park
Oral Health Therapist

White Cross Mobile Dental Care
Ground Floor, 141 Peats Ferry Road, Hornsby NSW 2077
Ph: 0414 570 785
Email:whitecrossmobiledentalcare@gmail.com

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 Name

____
Patient / Legal guardian signature

_ _ _ _ / _ _ _ _ _ / _
Patient's Medicare Number

____
Full name of person signing

_
Number on card

_ _ / _ _ _ _
Valid to

____
Guardian Contact No

____
Date

White Cross Mobile Dental Care

Child Health / Dental History Form

Patient Name:	Year/Class
Last:	First:
Date of Birth:	Sex: M ☐ F ☐
Parent's / Guardian's Name	
Contact No:	

Medical History

Has the child had any history of, or conditions related to, any of the following;

	Yes	No		Yes	No
Allergy Latex	☐	☐	Allergy Penicillin	☐	☐
Abnormal Bleeding	☐	☐	Asthma	☐	☐
Bronchitis	☐	☐	Diabetes	☐	☐
Epilepsy	☐	☐	Fainting / Dizziness	☐	☐
Hepatitis B or C	☐	☐	HIV / AIDS	☐	☐
Radiotherapy / Chemotherapy	☐	☐	Rheumatic Fever	☐	☐
High Blood Pressure	☐	☐	Anaesthetic Problems	☐	☐

List all medications: ____________________

Allergies: (other) ____________________

How does your child feel about having a dental examination?

Extremely Nervous ☐ Moderate Nervous ☐

Mild case of nerves ☐ Relaxed and confident ☐

How long is it since your child had seen a dentist?

More than 6 Months YES ☐ NO ☐

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NON – INVASIVE TREATMENT CONSENT FORM

I, the Parent / Legal guardian, give consent for my child ____________________
____________________to the following non-invasive treatments, provided by the Oral Health Therapist/Hygienist.

TREATMENT REQUESTED FORM

(Please tick)

Examination (Teeth & Gums) ☑ (required)
Scale / Clean / Polish ☐
Fluoride ☐
Fissure Sealants ☐
Temporary Filling ☐

I understand that the benefits will be covered under the Australian Government Child Dental Benefits Schedule, **with no out-of-pocket expenses**, even once the benefits are exhausted and/or the child is not covered by this Scheme (Medicare).

____
Parent/Legal Guardian Name

______________________________________ Date: ________________
Parent/Legal Guardian Signature

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