Dental Consent Form

Patient Details

Surname: ..... First Name: .....

DOB: ..... Aged Care Facility Name: .....

Dental Services

please select: Cost

☐ **Initial Preventative Appointment**
Comprehensive Examination, scale and fluoride treatment. Radiographs will be taken, if necessary, to determine any further treatment required to maintain healthy function.
Billed at standard MDS fee schedule capped at **$295**
Plus initial patient fee **$40**

☐ **Denture Only (Full dentures only)**
Examination and clean of dentures. Assessment of gum health and review of denture fit. If teeth are present then Initial Preventative Appointment will apply.
Billed at standard MDS fee schedule capped at **$125**
Plus initial patient fee **$40**

in addition, please tick your preference:

Yes ☐
No ☐

Urgent Treatment
During the appointment, the dentist may identify a condition requiring immediate pain relief / treatment. In some cases, leaving this may risk further degradation of condition and pain. (incl restorative, extractions and denture adjustments)
Billed at standard MDS fee schedule up to **$250**

Is there any specific information you would like to provide:

(e.g chipped tooth, family member to attend) .....

Initial Patient Fee is a one-off charge to cover costs to integrate the New Patient into our consent and administrative system, such as medical history and medication review, postage and communication. Refer to MDS FAQ's for more information.

Should further treatment be required, a comprehensive Dental Treatment Plan will be compiled, focusing on eliminating decay, infection and pain and maintaining healthy function. Mobile Dental Services will contact you after the appointment to discuss the outcome, any proposed treatment plan, costs and to obtain consent for further treatment (usually within 7 days of the appointment). Should no further treatment be required, you will receive a recommendation for ongoing review.

Consentee Details

Surname: ..... First Name: .....

Relationship to Patient: ..... Contact Phone: .....

I consent to Mobile Dental Services providing the nominated services. I acknowledge that I am financially responsible for the costs of this treatment.

Signature: ..... Date: .....

Payment

☐ DVA Gold Card (bulk bill) number .....

☐ Credit Card (Visa/MCard/Amex) Card No: .....Exp: ...../.....

☐ Send Account: (address or email) .....

Private Health (optional)

Name of Fund: .....

HICAPS is claimed if a card is presented at the appointment, alternatively a bill is issued for manual claiming