Queensland Government

Gold Coast Health

ORAL HEALTH CONSENT AND MEDICAL HISTORY

Facility: ______________________

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

TRIAL

ORAL HEALTH PARENTAL, LEGAL GUARDIAN, CARER CONSENT AND MEDICAL HISTORY

Please complete this form and return to GCOralHealthReferralHub@health.qld.gov.au / bring to the child's dental appointment:

Details of the child

Last name: ______________________ Title: __________

First name(s): ______________________

Alternate or previous name/s known by *(if applicable)*: ______________________

Date of birth: _____/____/_____

Gender: ☐ Male ☐ Female ☐ Other: ______________

Home address: ______________________

Phone (home): ______________________

Phone (work): ______________________

Phone (mobile): ______________________

Email: ______________________

I consent to receiving contact from the Oral Health Service by SMS and / or email ☐ Yes ☐ No

Postal address (*if different from home address*): ______________________

Contact person in case of emergency: ______________________

Relationship to child: ______________ Phone: ______________

Medicare Number: ______________ Line No: _____ Expiry Date: _____/_____

Healthcare Card *(if applicable)*: ______________ Expiry Date: _____/_____

Is the child of Aboriginal, Torres Strait Islander or Australian South Sea Islander origin? (*please tick ONE box*)

Your accurate response to the Indigenous status question assists Qld Health in delivering the best possible health care to all patients.

☐ No ☐ Aboriginal ☐ Torres Strait Islander

☐ Aboriginal and Torres Strait Islander ☐ Australian South Sea Islander

In which country was the child born?

☐ Australia ☐ Another country Name of the country: ______________

What language is spoken at home? ______________ Do you require an interpreter? ☐ Yes ☐ No

Is this child in the custody of the Department of Child Safety? ☐ Yes ☐ No

If yes, Department of Child Safety Branch details

Location: ______________________ Phone: ______________

Email: ______________________

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All clinical form creation and amendments must be conducted through Health Information Services

Date Reviewed – 02/2020
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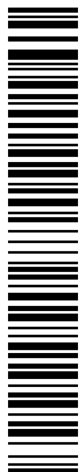
Material No:



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Consent to examination and preventative oral care

I consent to the child receiving the following:

- a dental examination, and
- dental x-rays, if considered necessary as part of the examination, and
- preventative oral care if considered necessary, such as oral hygiene assistance, cleaning of teeth and the application of flouride to the teeth

I understand that if the child requires further dental treatment, a parent / legal guardian / carer will be required to sign for the proposed treatment plan before it can proceed.

☐ **Yes, I consent** ☐ **No, I do not consent**

I consent to health professionals who have treated the child exchanging information about the child as may be required to assist in providing oral health care to the child. I also consent to information that has been collected by Queensland Health, when providing oral health care to the child, being used by Queensland Health to check and assess the oral health services the child has received and how those services have been used, so long as the child's name is not used in any reports or published statistics.

☐ **Yes, I consent** ☐ **No, I do not consent**

Please complete the following details regarding the child's dental and medical history

Dental History

Please list any relevant dental history (such as anxiety, trauma, orthodontic treatment or other): ______________

Is the child receiving other treatment from another dentist? ☐ Yes ☐ No if YES details:

Please list any concerns you have with the child's teeth / mouth: ______________

Medical History

Is the child currently being treated by a doctor or other medical specialist? ☐ Yes ☐ No if YES details:

Who is the child's usual medical practitioner? (Doctors name, practice name): ______________

Please list any tablets or medications (prescribed or over the counter) that the child takes: ______________

Please list any known allergies (such as latex, penicillin or other): ______________

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Medical History continued

If applicable, please advise of any previous hospitalisations / operations (under general anaesthetic):

____

____

Does the child smoke? ☐ Yes ☐ No

Is the child pregnant (females only)? ☐ Yes ☐ No

Please complete the relevant sections:

Mental Health

☐ Depression

☐ Anxiety

Details / other: ______________________

Disability

☐ Intellectual

☐ Physical

☐ Sensory (hearing, speech, vision)

Details / other: ______________________

Behavioural

☐ Attention Deficit Hyperactivity Disorder (ADHD)

☐ Autism Spectrum Disorder (ASD)

Details / other: ______________________

Oncology

☐ Chemotherapy

☐ Radiation Therapy

Details / other: ______________________

Respiratory

☐ Asthma

☐ Bronchitis

☐ Tuberculosis

Details / other: ______________________

Central Nervous System

☐ Epilepsy

☐ Cerebral Palsy

Details / other: ______________________

Cardiovascular

☐ Heart valve pathology

☐ Congenital heart disease

☐ Heart murmur

Details / other: ______________________

Endocrine

☐ Diabetes

☐ Thyroid disorder

Details / other: ______________________

Bleeding disorders

☐ Haemophilia

☐ Sickle Cell Disease

Details / other: ______________________

Developmental conditions

☐ Syndromes

Details / other: ______________________

Gastro-intestinal

☐ Reflux

Details / other: ______________________

Please note details regarding any other condition/s not listed above: ______________________

____

____

____

Parent / legal guardian / carer name (print): ______________________

Signature: ______________________ Date: _____/_____/_____

Office use only:

Clinician name (print): ______________________ Signature: ______________ Date: _____/_____/_____

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CHILD DENTAL BENEFITS SCHEDULE BULK BILLING PATIENT CONSENT FORM

(for services provided in a Queensland Health public sector dental clinic)

I, the parent / legal guardian / carer, 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 pay out-of-pocket costs for these services subject to sufficient funds being available under the benefit cap. Once my benefit cap has been reached I will not need to pay any out-of-pocket costs provided I am eligible for services in a Queensland public dental health clinic

I understand that I / the parent / legal guardian / carer 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 or Queensland Public Dental Services.

I understand that the costs of services will reduce the available benefit cap and that I will need to personally meet the costs of any additional services not covered by Queensland Public Dental Services once benefits are exhausted.

Medicare number: ______________________________ Line No: _____ Exp Date: _____/_____

Child's name:

Last name: ______________________________

First name/s: ______________________________

Parent / legal guardian / carer name (print): ______________________________

Signed (Parent / Legal Guardian / Carer): ______________________________ Date: _____/_____/_____

The Child Dental Benefits Schedule Consent form **is valid up to 31 December of the calendar year for which it is signed.**

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Permission given by Metro North Oral Health Service to use & adapt