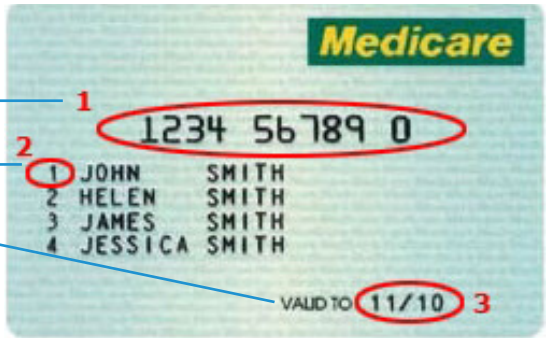
The School Dentist

Brought to you by Future Care Mobile Dental Services

Child Care Centre Consent Form

Name of Centre			
Family Name		First Name	
Gender		Date of Birth	
Parent/Guardian Name		Contact number	
Home address			
Email address			

Medicare Card Number	
Child Individual Reference Number	
Expiry Date	



Please tick if you agree to the following:

- ☐ 1. Please conduct Medicare eligibility check
- ☐ 2. If eligible and recommended by our dentist, please provide free oral examination / clean / fluoride / fissure seals / temporary fillings
- ☐ 3. If not eligible, please provide oral examination / clean / fluoride for $79

Can my child still be seen if they are not eligible for the free dental service?

YES! Our Dentist can see your child and provide them with an oral examination, clean and fluoride for just $79. We will provide you with a receipt and you can claim on your private health insurance if applicable.

Call our team on 9723 0333
for more information

www.fcmdental.com.au | admin@fcmdental.com.au

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Medical History Questionnaire

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	
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, milk protein, etc):			

I agree that the above is a true and accurate record. Please note, this form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments. Please see our website for our privacy statement. By signing below I consent to my child to receiving part or all of aforementioned treatments as recommended by the dentist.

Child's Name: _____ **Date of Birth:** _____/_____/_____

Parent/Guardian Signature : _____ **Date:**_____/_____/_____

Payment Options

Please tick your preferred payment option:

☐ Pay via credit card

Name on credit card	
Credit card number	
Expiry date (MM/YY)	
CCV	
Amount payable	$79

☐ Pay via direct deposit

Our account name	Future Skills Network Group
BSB	012 110
Account Number	295 987 518
Please put your child's full name as the reference	

☐ Pay via PayPal

To pay via PayPal, download the PayPal app or log onto the PayPal website. When asked, our email address is accounts@fcmdental.com.au. Follow the prompts from there to pay $79 for the service.