Mobile DentalCareSA

Patient / Guardian Information & Consent Pack

The team at Mobile Dental Care SA are committed to providing a full range of mobile dental services to the community including residents within aged care facilities, residential living complexes and even home dental visits for disabled and bed-ridden patients.

Our mobile dental team have extensive experience in providing dental treatment services for patients of all ages and backgrounds.

To keep out of pocket expenses down, we bulk bill Veterans Affairs (DVA) gold card holders and participate in all government assistance schemes such as the Pensioner Denture Scheme (PDS), Emergency Dental Scheme (EDS) and General Dental Schemes (GDS).

Those insured with private health will also be able to access cost-effective onsite dental treatment with potential rebates available once full payment has been made to Mobile Dental Care SA.

Please complete the attached consent forms in as much detail as possible as this will enable provision of high quality care in the most cost effective and efficient means for all residents/patients.

If you have any questions regarding the information package, or regarding the Community Outreach Program, please don't hesitate to contact Mobile Dental Care SA directly via phone (08 8361 8074) or email our Program Manager, Jan at: mobiledentalcaresa@gmail.com

Yours Sincerely,

Jan
Community Outreach Program Manager

Mobile Dental Care SA
PO Box 366
North Adelaide SA 5006
Email: mobiledentalcaresa@gmail.com

Mobile DentalCareSA

Part 1: Facility Details

(This section to be completed by the Facility Co-ordinator/Site Manager)

Name of Facility:

Address:

Staff Contact: Phone number:

Email: Fax:

Part 2: Patient Details

(The remainder of this document to be completed by the Patient/Guardian)

Full Name: (Mr, Mrs, Ms, etc)

Preferred Name:

Date of Birth: Phone number:

Postal Address:

DVA SX number: (Dept. Of Veterans Affairs gold card only)

Private health insurance: Reference number:

Part 3: Patient Information

Does the Patient have (or have they had) any of the following conditions? Please tick Yes or No

Heart trouble of any kind	Yes	No	Requires blood thinners	Yes	No
High blood pressue	Yes	No	Asthma	Yes	No
Epilepsy	Yes	No	Diabetes	Yes	No
HIV (AIDS)	Yes	No	Allergic to Penicillin	Yes	No
Rheumatic Fever	Yes	No	Hepatitis A B or C (please specify)	Yes	No
Any known allergies	Yes	No	Please detail		
Currently taking any medication	Yes	No	Please detail		
Difficulty swallowing	Yes	No	If Yes, why?		

Is the patient able to lay in the dental chair without assistance? Yes No

Is the patient able to walk without assistance? Yes No If No, Please detail what assistance is needed (e.g. wheelchair)

Any other serious illnesses, adverse reactions to prior dental treatment or any other comments you'd like to make Yes No

If yes, please detail here (and overleaf if necessary)

Please list any dental concerns or problems the patient has described or has been identified by a carer:

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Part 4: Next of Kin/Guardian Details

Full Name: (Mr / Mrs / Ms, etc)

Phone number:

Address:

Part 5: Patient/Guardian Consent & Billing Details

I, confirm I am the ☐ Patient (if self consenting) ☐ Legal Guardian

of, and hereby consent to the Community Outreach Program collecting relevant information to assist in the provision of dental care and to provide the dental treatment required during the upcoming appointment.

Signed Date

A Mobile Dental Care SA representative will contact the patient or guardian to discuss the proposed services/treatment to be provided and any applicable charges.

Billing Address

Unless otherwise specified, any invoices will be sent to the address provided in the 'Patient Details' section. If you would like the invoice sent to an alternative address, please list the details below:

Part 6: Photocopies

Please provide photocopies of the following documents:

- Current Medical History
- Current Medication Chart/History