New Patient Dental Consent Form

Date

Who is Giving Dental Consent and Filing This Form?

Please tick (✔) the appropriate box to indicate who is giving consent for the resident's dental treatment and filing this form:

☐ A. The Resident (Patient) – Do not fill section B & C

☐ B. Aged Care Facility – Fill section A & B

☐ C. Carer / Guardian / Legal Representative / Next of Kin / Other – Fill section A & C

(By ticking a box above, the person filing and consenting agrees to the responsibilities outlined on page 4 of this form.)

Section A- Patient

Title: ○ MR ○ MRS ○ MS ○ DR Other

Given name Surname D.O.B

Is the patient Aboriginal or Torres Strait Islander? ○ No ○ Yes

Contact Number

Medicare # Ref # Expiry

GP name GP phone GP address

Emergency contact Relationship to patient

Aged Care Facility Name:

Address

suburb State postcode Phone number

Aged Care Facility Email

Section B- Aged Care Facility

If the Aged Care Facility is giving consent and filing the form, please complete the following:

Facility Name:

Facility Representative Full Name: Position/Title:

Contact Number:

Signature of Facility Representative: Date:

Section C- Carer / Guardian / Legal Representative / Next of Kin / Other

If a Carer, Guardian, Legal Representative, Next of Kin, or Other Party is giving consent and filing the form, please complete the following:

Full Name of Person Filing Form: Relationship to Resident:

Contact Number: Email Address:

Signature of Person Filing Form: Date:

Medical History

Please tick if the patient has ever had any of the following:

- ☐ Abnormal/excessive bleeding
- ☐ Angina
- ☐ Artificial heart valve
- ☐ Asthma
- ☐ Blood disorder (name below)
- ☐ Blood pressure (high/low)
- ☐ Blood thinner
- ☐ Bone disease (e.g. Osteoporosis)
- ☐ Difficulty swallowi
- ☐ Cancer
- ☐ Current or past Bisphosphonate
- ☐ Cardiac surgery/pacemaker
- ☐ Congenital heart defect
- ☐ Congenital heart defect
- ☐ Epilepsy
- ☐ Hearing impairmer
- ☐ Neurological disorder
- ☐ Heart murmur
- ☐ Hepatitis A/B/C/D
- ☐ HIV positive
- ☐ Rheumatic fever
- ☐ Other condition(s) name
- ☐ Oral ulceration
- ☐ Prosthetic joints
- ☐ Prosthetic joints
- ☐ Radiation/chemotherapy
- ☐ Reflux
- ☐ Kidney/liver disease
- ☐ Steroid therapy
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Immune deficiency
- ☐ Hip fracture
- ☐ Visual impairment
- ☐ Tubertculosis
- ☐ Alzheimer's or dementia
- ☐ Chronic mental illness
- ☐ diagnosed depressior
- ☐ Parkinson's disease

- Has the patient been hospitalised in the last three months? ○ No ○ Yes If yes, please specify the reason

- Does the patient require antibiotic cover before dental treatment? ○ No ○ Yes ○ Not Sure

If unsure, please consult the patient's GP or cardiologist and provide their advice before treatment.

- Does the patient smoke? ○ No ○ Yes If yes, how often?

- Is the patient taking any medication (including natural supplements)? If yes, please list them or attach a list provided by the GP.

Allergies

☐ Aspirin ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulpha drugs ☐ Dairy/Milk

Other (please specify):

Dental history

Last dental visit: Is there any specific dental issues or concern?

Has the patient ever had a reaction or complication following dental treatment in the past? ○ No ○ Yes

if yes, please detail

Is there anything else the dentist or hygienist should be aware of ?

Dental history

Is the patient suffering from any of the following?

☐ Bad appearance of teeth	☐ Discoloured teeth	☐ lost filling/cavity	☐ Toothache
☐ Bad breath	☐ Dry mouth	☐ Rapidly decaying teeth	☐ Unsatisfactory denture
☐ Grinding/clenching	☐ pain in face/jaw	☐ worn or broken teeth	☐ Difficulty chewing
☐ Loose teeth	☐ Sound from joints		

Dental Visit Type (Please tick the appropriate box)

☐ Emergency Dental Visit

I acknowledge that the Emergency Dental Visit includes a consultation and examination for a fee of $200, plus a $60 travel fee (total: $260, payable before the visit). Following the emergency consultation, the dental provider will prepare a treatment plan or dental report outlining the resident's oral health needs. This document will specify any required treatment and will be sent to the email address provided.

I agree to the following:

- The treatment plan and its associated costs will be provided via email.
- I must review, approve, and provide payment for the treatment plan on the same day before any additional dental work can proceed.
- I am responsible for replying promptly to the email to ensure that the necessary treatment can be completed on the same day.

Full name of the person responsible for payment above: _____

Signature: X_____ **Date** _____

Routine Dental Visit

☐ Examination only – $95

☐ Examination ,Teeth Cleaning, Teeth Polishing & Fluoride Treatment – $250

☐ Denture Cleaning – $60

Total Amount That I Agree and Selected is Payable Before the Dental Visit:$ _____

Patient/Representative Full Name: _____

Signature: X_____ Date _____

Trustee or Other Party Responsible for Payment

If the person responsible for paying the dental fees is not the same as the person giving consent for the dental visit, please complete the following:

Full Name _____ Relationship to Resident: _____ Contact Number: _____

Email Address: _____

By completing this section, the person responsible for payment acknowledges and accepts full responsibility for:

- Ensuring that all dental payments for the resident's treatment are made in a timely manner.
- Any other payments agreed upon by the patient or the person providing consent for the dental treatment.
- Understanding that they are financially responsible for the costs associated with the dental treatment and any related services.
- **Signature of Payment Responsible Party:** _____ **Date:** _____

Agreement & Acknowledgment

By signing below, the person filing the form (whether the patient themselves, legal representative, carer, or authorised representative of the aged care facility) agrees to the following:

- Providing Accurate Information: Ensuring that all details regarding the patient's medical history, current medications, and allergies are accurate and up to date.
- Informed Consent: Giving consent for the dental consultation and all necessary dental treatments, including examinations, procedures, and any recommended interventions.
- Financial Responsibility: Taking full responsibility for the financial dental treatment, including payment for all services rendered to the patient before and after treatment.
- Agreeing to pay in advance for an Emergency Dental Visit or Routine Check-up, as outlined in this form.
- Acknowledging and agreeing to the payment and response requirements in the Emergency Dental Visit section, including reviewing and approving the treatment plan, making payment on the same day, and promptly replying to emails to avoid delays in treatment.
- Confidentiality & Compliance: Respecting the confidentiality of the patient's personal and medical information and ensuring compliance with all relevant laws and privacy regulations.
- Communication: Effectively communicating with the dental professional and other healthcare providers as needed.

Legal Notice Regarding Payment Responsibility

- Additionally, I acknowledge and agree to the following: Legal Obligation for Payment: Once treatment is provided and this form is signed, I am legally obligated to cover all costs, including consultation fees and any additional medical or dental procedures.
- Non-Payment Consequences: If I fail to make payment, claim that someone else is responsible, or refuse to pay, I will be fully liable for all outstanding costs, including legal fees, attorney costs, and any financial losses incurred due to non-payment.
- Legal Action for Non-Payment: The dental provider has the right to take legal action to recover any outstanding balance, which may include filing a lawsuit, taking legal action, and imposing any penalties allowed by law.
- Responsibility Transfer in the Event of Death: In the event of my death, the responsibility for payment shall be transferred to my estate.
- Estate Liability: My estate will be responsible for all unpaid treatment costs, including any accrued or future costs arising from ongoing treatment.
- Claims Against the Estate: The dental provider reserves the right to pursue my estate for any outstanding balances and may take necessary legal actions, including filing claims in probate court.
- Legal Costs: The provider may initiate legal proceedings to recover owed funds, including attorney fees, court costs, and any other financial losses resulting from non-payment.

I,[Full Name] _____ Relationship _____ to the patient

[Full Name] _____ understand that I am responsible for providing accurate and up-to-date information regarding the patient's medical history, medications, and emergency contacts. I hereby consent to the dental consultation and treatment and agree to the terms and conditions set forth in this form. I also acknowledge that I am fully responsible for all payments related to the patient's dental treatment, including any fees outlined in this form.

Signature : _____ Date _____

- Payment can be made through

  Account Name: PSD SMILE WITH ME PTY LTD
  BSB NO: 062-516
  Account NO: 1047 9385
- Cash payments are accepted