Oral Health Services – Medical and Dental Questionnaire

Queensland Government

CHILD'S DETAILS

Family name:

Given name(s):

Preferred name(s):

Date of birth: / /

Relationship to child:

Birth Sex: ☐ Male ☐ Female ☐ Other:

Gender: ☐ Male ☐ Female ☐ Non Binary ☐ Prefer not to answer ☐ Other:

Variations to sexual characteristics:
☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

Client pronouns:
☐ They, Them, Their, Theirs, Themself
☐ He, Him, His, Himself
☐ She, Her, Hers, Herself
☐ Uses other pronouns
☐ Unknown pronouns
☐ Prefer not to answer

Language spoken at home:

Interpreter required? ☐ Yes ☐ No

Indigenous status:
☐ Aboriginal but not Torres Strait Islander origin
☐ Torres Strait Islander but not Aboriginal
☐ Both Aboriginal and Torres Strait Islander
☐ Not Aboriginal or Torres Strait Islander
☐ Not stated / unknown

Australian South Sea Islander status:
☐ Yes ☐ No ☐ Not stated / unknown

School: **Year:**

Child's Medicare number:

IRN: *The IRN is the number which appears next to your child's name.*

Expiry: MM / YYYY

Admin use only:
☐ **CDBS checked** ☐ **HBCIS checked**

PARENT/CARER DETAILS

Family name:
Given name(s):
Home address:
Postcode:
Phone:
Email:

Doctor's details:
Doctor name:
Practice name:
Phone number:

CONSENT

I consent to my child/ren receiving the following:

- a dental examination – including dental xrays if considered necessary as part of the examination
- preventive oral care if considered necessary, such as oral health education, cleaning of teeth and the application of enamel strengthening/remineralising agents (e.g. fluoride) to the teeth.

I understand that the examination (and associated procedures deemed necessary) may involve more than one appointment and that separate consent will be required should further treatment be recommended.

I consent to other health professionals being consulted where it will assist in the provision of my child's oral health care.

I consent to health professionals who have treated my child exchanging such information about my child as may be required to assist in providing oral health care to my child. I also consent to information that has been collected by the Department of Health, in the course of my child's oral health care, being used by the Department of Health to check and asses the oral health services my child has received and how such services have been used, provided my child's name is not used in any reports or published statistics.

I consent to be contacted by phone, text or email from the information I have provided.

I understand that if my child is eligible for treatment under the Child Dental Benefits Schedule, I must read the likely costs of an examination and preventative oral care as listed and complete the attached Child Dental Benefits Schedule Bulk Billing Patient Consent form.

Name:	**Signature:**	**Date:** / /

Please turn over and complete page 2

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Medical history	Yes	No	Details
Is your child taking any tablets or medicines? *(Prescribed, over-the-counter including any natural therapy medications)*			
Is your child allergic to any drugs, medications, latex?			
Has your child had any previous hospitalisations or operations under general anaesthetic?			
Is your child pregnant?			
Does your child have any abnormal reactions to local or general anaesthesia?			
Does your child smoke or vape?			
Is your child receiving treatment from another dentist/ orthodontist, dental specialist?			
Have you any concerns with your child's teeth?			
Have you been advised that your child requires antibiotic cover prior to dental treatment?			
Does your child have, or has your child ever had, any of the following conditions?			
Rheumatic fever			
Heart complaint			
Heart valve disorder, e.g. murmur			
Cardiac pacemaker			
Cystic Fibrosis			
Asthma / bronchitis			
Tuberculosis			
Neurodiversity e.g. ADHD, ASD			
Epilepsy			
Stroke			
Developmental conditions, e.g. syndromes			
Growth disorder			
Diabetes			
Thyroid disease			
Stomach or digestive disorder			
Kidney disease			
Bleeding disorder e.g. von Willebrands, haemophilia			
Leukaemia			
Anaemia			
Hepatitis or liver disease			
Steroid therapy			
Contact with HIV/AIDS virus			
Cancer treatment – chemotherapy and/or radiation			

Associated Bulk Billing Costs (for treatment under CDBS only)
Treatment costs set by the Federal Government for initial examination, dental x-rays (if required) and preventive treatment

Medicare Item Number	Description of treatment	CDBS bulk billed fee (as at January 2026
88011	Comprehensive oral examination	$60.95
88022	Intraoral periapical or bitewing radiograph (dental x-ray) per exposure (usually one radiograph of each side is required)	$35.30 each
88114	Removal of calculus – first visit	$103.90
88121	Topical application of remineralisation and/or cariostatic agents	$40.05

Parent/Guardian signature: **Date**: / /

Office use only *(checked by operator)* Staff name: Signature: Date: / /

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Child Dental Benefits Schedule
Bulk Billing Patient Consent Form

Australian Government

Department of Health, Disability and Ageing

About this Program

The Child Dental Benefits Schedule (CDBS) is an Australian Government program that provides access to basic dental services, within a benefit cap, over a relevant two calendar year period. Services that receive a benefit under the CDBS include examinations, cleaning, x-rays, fissure sealing, fillings, root canals, extractions and partial dentures. The full list of services is available in the Dental Benefits Schedule. The Schedule includes an item number, description, benefit amount and applicable restrictions for each service. Services can be provided in a public or private setting. However, benefits are not available for orthodontics, cosmetic dental or any services provided in a hospital.

A child is eligible for the CDBS if they are:

- 0-17 years old for at least one day that calendar year;
- Eligible for Medicare; and
- Receive a payment from Services Australia at least once a year, or have a parent, carer or guardian who receives a payment from Services Australia at least once a year.

Privacy and Consent information

Your personal information is protected by law, including the *Privacy Act 1988* and the Australian Privacy Principles (APPs), and is being collected by your Dental Provider on behalf of the Department of Health, Disability and Ageing (the department). for the primary purpose of facilitating basic dental services under the Child Dental Benefits Schedule.

If you do not provide this information services will not be able to be provided to you under the CDBS.

By providing your personal information to your Dental Provider you consent to the department collecting this personal information about you from your Dental Provider.

You can access the department's APP privacy policy at https://www.health.gov.au/resources/publications/privacy-policy

The department can be contacted by telephone on (02) 6289 1555 or via email at privacy@health.gov.au

The department will not disclose your personal information to any overseas recipients.

Patient's details

Medicare card number **Ref**

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Given Name

Family Name

Date of Birth

I, the patient/parent/legal guardian 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 and the likely cost of this treatment;
- That I will be bulk billed for services under the Child Dental Benefits Schedule;
- There will be no out-of-pocket costs for dental services provided within a public clinic; and
- That benefits for some services may have restrictions, and that the Child Dental Benefits Schedule covers a limited range of dental services.

NB: This form is valid up to 31 December of the calendar year for which it is signed.

Full name (print in BLOCK LETTERS)

Signature

Date

Patient ☐ Parent ☐ Legal Guardian ☐
(tick one only)