FOR PARENTS & GUARDIANS

Information & consent package

Everything you need before your child's visit. A quick read, then one simple form to complete. We're here to make it stress-free.

ABOUT US

Prevention first, always gentle

At Pearly, we're redefining dental care by focusing on prevention, not just treatment. Our expert team prioritises patient education, affordable and accessible care, and a stress-free experience.

We're committed to proactive treatments that keep your smile healthy and boost your confidence, making every visit enjoyable and effective.

A program kids actually love

Pearly introduces a fun, engaging educational program designed for kids, teaching them to care for their smiles: brushing, flossing, and healthy tooth-friendly foods. Best of all, it's free for eligible kids under the CDBS. For those not covered, we offer special discounted rates.

CHILD DENTAL BENEFITS SCHEDULE

Patient consent form

Please complete this form for your child before treatment. If anything is unclear, our team is happy to help on the day.

01 PRIVACY & CONSENT

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 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.

02 IS MY CHILD ELIGIBLE?

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.

Not sure? Fill in the details below and we'll check eligibility for you.

03 YOUR CHILD'S DETAILS

CHILD'S NAME

CLASS

GENDER

○ Male ○ Female

DATE OF BIRTH

D D / M M / Y Y Y Y

CONTACT NUMBER

EMAIL ADDRESS

MEDICARE NUMBER · the 10-digit number on your green Medicare card

CHILD'S REF. NUMBER ON CARD

The number beside your child's name on the card.

CARD VALID TO

M M / Y Y Y Y

Please continue on page 2 →

Consent & signature

04 CONSENT & CERTIFICATION

I, the patient / parent / legal guardian certify that I have been informed:

- Of the treatment that has been or will be provided on this day under the Child Dental Benefits Schedule and the likely cost of this treatment;
- The billing and payment arrangements for the services;
- That services may incur an out-of-pocket cost;
- In addition to the out-of-pocket costs discussed, I understand that the cost of services will reduce the available benefit cap and I will need to meet the cost of any additional services once benefits are exhausted; and
- That benefits for some services may have restrictions, and that the Child Dental Benefits Schedule covers a limited range of dental services.

Please tick one:

☐ **Treatment under the CDBS (bulk billed)**
I give permission for my child to receive a dental examination and treatment under the CDBS.

☐ **Treatment with out-of-pocket costs (non-bulk billed)**
I give permission for my child to receive a dental examination and treatment, and agree to pay out-of-pocket if my child is not eligible under the CDBS.

05 SIGNATURE

PARENT / LEGAL GUARDIAN'S FULL NAME · in BLOCK LETTERS

SIGNATURE

DATE

D D / M M / Y Y Y Y

NB: This form must be completed on each day of service provision under the Child Dental Benefits Schedule.

CHILD DENTAL BENEFITS SCHEDULE

Patient consent form

Bulk & non-bulk billing
Version date: June 2025

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CONSENT & CERTIFICATION

I, the patient / parent / legal guardian certify that I have been informed:

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- The billing and payment arrangements for the services;
- That services may incur an out-of-pocket cost;
- In addition to the out-of-pocket costs discussed, I understand that the cost of services will reduce the available benefit cap and I will need to meet the cost of any additional services once benefits are exhausted; and
- That benefits for some services may have restrictions, and that the Child Dental Benefits Schedule covers a limited range of dental services.

PATIENT DETAILS

CHILD'S NAME

CLASS

GENDER

○ Male ○ Female

DATE OF BIRTH

D D / M M / Y Y Y Y

CONTACT NUMBER

EMAIL ADDRESS

MEDICARE NUMBER · 10 digits on your green Medicare card

REF. NUMBER ON CARD

Beside your child's name.

CARD VALID TO

M M / Y Y Y Y

☐ **Under the CDBS (bulk billed)**
I give permission for my child to receive a dental examination and treatment under the CDBS.

☐ **Out-of-pocket (non-bulk billed)**
I give permission for my child's treatment and agree to pay if not eligible under the CDBS.

GUARDIAN'S FULL NAME · BLOCK LETTERS

SIGNATURE

DATE

D D / M M / Y Y

NB: This form must be completed on each day of service provision under the Child Dental Benefits Schedule.