THE UNIVERSITY OF WESTERN AUSTRALIA | Oral Health Centre of Western Australia

Oral Health Centre of Western Australia
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OHCWA - DENTAL TREATMENT APPLICATION

OFFICE USE ONLY	
WAIT LIST	SUB CAT

ELIGIBILITY INFORMATION

The Oral Health Centre provides emergency, general, and specialist treatment to Western Australians who are holders of a current Healthcare or Pension Concession Cards. If you receive a pension or benefit the cost of your treatment may be subsidised, based on the level of payment you receive. Treatment can only be provided to patients who are eligible at the time they are offered an appointment. To assess eligibility please complete all required information below which includes authorisation for Centrelink to electronically provide a statement. You will also need to provide a photocopy of your current Healthcare or Pension Concession Card in this application.

Section 1 – PATIENT DETAIL

Title: ______________ Last name: ____

First Name(s): ____________________________________ Date of Birth: _____/_____/_________ *(DD/MM/YYYY)*

Sex at birth: ☐ Male ☐ Female ☐ Prefer not to answer ☐ Other ____________________________

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to answer ☐ Different term ______________

Country of Birth: _________________ Preferred Language: _____________________ ☐ Interpreter needed

Are you of Aboriginal or Torres Strait Island Origin? ☐ Aboriginal ☐ Torres Strait ☐ Neither

Address: ____ Suburb: ____________________________

Post Code: __________ Mobile: ______________________ Alternate phone: ________________________

Email: ____ Medicare No: ____________________________

I consent for my appointment reminders be sent to the mobile number by a third party provider: ☐ Yes ☐ No

Section 2 – NEXT OF KIN/PARENT/GUARDIAN

Title: ______________ Last name: ____

First Name(s): ____

Address: ____ Suburb: ____________________________

Post Code: __________ Mobile: ______________________ Alternate phone: ________________________

Email: ____ Relationship to patient: ________________________

Section 3 – PAYMENT DETAILS

Parent or Guardian Responsible for Payment: *(Must be Centrelink Main Card Holder for Parent(s))*

Title: ______________ Last name: ____

First Name(s): ____________________________________ Date of Birth: _____/_____/_________ *(DD/MM/YYYY)*

Address: ____ Suburb: ____________________________

Post Code: __________ Mobile: ______________________ Alternate phone: ________________________

Email: ____

***** Please turn over *****

Section 4 – ELIGIBILITY

Type of Card: ☐ Pensioner ☐ Healthcare Card ☐ Veterans Affairs: Colour ________________

Card Holder CRN Number: __________________________ Expiry Date: _____/_____/_________ *(DD/MM/YYYY)*

Patient CRN Number: ______________________________ Expiry Date: _____/_____/_________ *(DD/MM/YYYY)*

Section 5 – EDUCATIONAL/RESEARCH CONSENT *(please tick)*

☐ I authorise OHCWA and The University of Western Australia to utilize any information or dental records gathered for educational or research purposes provided the material is de-identified.

Section 6 – CONSENT TO OBTAIN INFORMATION *(please tick)*

☐ I authorise Centrelink to electronically provide a statement of information to the Oral Health Centre and their agents to assist in assessment of my entitlement to concessions or services from the Oral Health Centre.

☐ I understand that the information provided by Centrelink may include relevant, current or historical details of payments received, dependents, Centrelink deductions, income assets and confirmation of my current address. I understand that this authority, which is ongoing, can be revoked at any time by giving written notice to the Oral Health Centre and Centrelink. I understand that I will be able to obtain a written copy of the Statements at any time from Centrelink.

☐ I understand that information provided as above, and all personal information provided by me and collected in the course of my treatment will be confidential, used only for the purposes of eligibility and treatment, and will be managed in accordance with UWA's Information Privacy Policy

Signature of Centrelink Main Card Holder: ___________________________________

Date: _____/_____/_________ *(DD/MM/YYYY)*

***** Please turn over *****