

# BUNBURY - 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 DETAILS

Title: \_\_\_\_\_ Surname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Given Names: \_\_\_\_\_

Sex at Birth: Male  Female  I prefer not to say  Other

Gender: Male/Man  Woman/Female  Non-binary  Different term  Prefer not to answer

Country of Birth: \_\_\_\_\_ Preferred Language: \_\_\_\_\_ Do you require an interpreter?

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

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_ Medicare No: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

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

### Section 2 – NEXT OF KIN/PARENT/GUARDIAN

Title: \_\_\_\_\_ Surname: \_\_\_\_\_

Given Names: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

### Section 3 – PAYMENT DETAILS

Parent or Guardian Responsible for Payment – must be Centrelink Main Card Holder

Title: \_\_\_\_\_ Surname: \_\_\_\_\_

Given Names: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Post Code: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

### Section 4 – ELIGIBILITY

Type of Card: Pensioner  Healthcare Card  Veterans Affairs  Colour \_\_\_\_\_

Card Holder CRN Number: \_\_\_\_\_ Expiry Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient CRN Number: \_\_\_\_\_ Expiry Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Section 5 – CONSENT TO OBTAIN INFORMATION

- 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, where relevant, current or historical details of payments received, dependants, 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.

Signature of Centrelink Main Card Holder: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_