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 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: ______/______/________