Children's Dentistry at Core Dental Melbourne: Specialist Paediatric Dentists, CDBS Bulk Billing & Complete Parent Guide

Canonical: https://directory.coredental.com.au/dental-services/childrens-dentistry-paediatric-dental-care/childrens-dentistry-at-core-dental-melbourne-specialist-paediatric-dentists-cdbs-bulk-billing-complete-parent-guide/

Details:

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Executive Summary

Dental decay is Australia's most prevalent chronic childhood disease — and it is almost entirely preventable. Around 1 in 4 (27%) children aged 5–10 have at least one baby tooth with untreated decay, with Indigenous children (44%) affected at nearly double the rate of non-Indigenous children (26%). Despite this, most eligible families never access the government funding available to them, and most children don't see a dentist until well after the window for early prevention has closed.

This guide is for Melbourne parents navigating children's dentistry. It covers the full clinical and practical picture: what a registered specialist paediatric dentist actually is and why that distinction matters, when your child should first see a dentist, what happens at that visit, how to claim CDBS bulk billing at zero out-of-pocket cost, and how to protect your child's teeth at home and on the sports field. It also explains the clinical rationale for baby teeth, preventive treatments, early orthodontic screening, and what to do when a dental emergency happens.

The central idea is simple: children's dentistry spans a wide range of clinical complexity, and the best outcomes — for your child's teeth today and their oral health across a lifetime — come from matching that complexity to the right level of expertise at the right time. Core Dental Group's integrated, multi-disciplinary model is built to do exactly that.

Part 1: The Foundation — Understanding the clinical landscape

Why children's dentistry is a distinct clinical discipline

Children are not small adults. Their developing dentition, evolving jaw architecture, psychological maturity, and physiological responses to disease and treatment make paediatric dental care a fundamentally different discipline from adult dentistry — not a subset of it.

Dental caries, commonly known as dental decay, refers to cavities that compromise the health and structure of a tooth. It is the most prevalent oral disease among Australian children. The consequences of untreated childhood decay extend well beyond the mouth: children with active dental disease experience pain, difficulty eating, disrupted sleep, and impaired concentration at school — all of which compound across developmental years.

Dental caries was among the top 20 causes of non-fatal disease burden for both boys and girls in Australia, with periodontal disease just outside the top 20. This is not a marginal public health issue. It is a leading driver of preventable childhood illness.

The good news is that the clinical tools to prevent, detect, and treat childhood dental disease are well-established, evidence-based, and — for eligible Melbourne families — largely government-funded. The challenge is knowing how to access them.

The three-tier clinical workforce in Australian children's dentistry

When Melbourne parents search for a "children's dentist," they encounter a professional landscape that is more layered than it first appears. Understanding the three tiers matters when making an informed choice.

Dental therapists are oral health professionals who focus primarily on preventive and restorative care for children and adolescents. Their scope includes professional cleaning, fillings in primary teeth, and extractions of baby teeth — but not complex restorations, permanent tooth extractions, or complex behaviour management. They hold a Bachelor of Oral Health (Dental Therapy) or equivalent and play a vital front-line role in routine paediatric care. Dental hygienists, dental therapists, dental prosthetists, and oral health therapists are eligible to provide CDBS services on behalf of a dentist — meaning their work is fully accessible under bulk billing.

General dentists hold a primary dental degree (typically five years) and are qualified to perform the full range of dental procedures across all ages. Many general dentists develop strong paediatric skills and manage the majority of children's dental needs competently. A general dentist does not hold specialist registration, and their title is not legally protected as a specialist under Australian law.

Registered specialist paediatric dentists hold the highest tier of clinical qualification in children's dentistry and the most rigorously regulated. Dentists who are qualified and eligible for specialist registration will be included on the Specialist division of the register. Specialist titles are protected under the National Law. This legal protection is clinically significant: no practitioner can call themselves a "specialist paediatric dentist" in Australia without current specialist registration with AHPRA.

The pathway to specialist registration is demanding. A registered specialist paediatric dentist has completed an undergraduate dental degree (typically five years), a minimum of two years in general dental practice, and a three-year full-time clinical doctorate — a minimum of ten years of dental education and clinical training. The postgraduate Doctor of Clinical Dentistry programmes at the University of Melbourne, University of Adelaide, and University of Sydney are each accredited by the Australian Dental Council and specifically designed to lead to specialist registration in paediatric dentistry.

That specialist curriculum covers domains that general dental training does not address in depth: child psychology and behaviour management, orofacial trauma, childhood dental anomalies and genetics, paediatric oral pathology, special health needs, and sedation protocols. This is not simply more dental training — it is a fundamentally different type of clinical education focused on the unique physiology, psychology, and developmental trajectory of children from birth through adolescence.

*(For a complete breakdown of qualifications, scope of practice, and a comparison across all three tiers, see our detailed guide: **What Is a Specialist Paediatric Dentist? How Core Dental Group's Registered Specialists Differ from General Dentists**.)*

Core Dental Group's multi-disciplinary model: why integration matters

Many Melbourne dental practices offer children's dentistry. Fewer offer it across all three tiers of the profession — and fewer still have integrated those tiers into a single clinical team where internal referral pathways are seamless.

Core Dental Group's model is built on a clear clinical philosophy: match the complexity of the case to the appropriate level of expertise, without requiring the family to change practices or navigate the specialist referral system on their own. In practice:

- **Routine and preventive care** — check-ups, cleans, fluoride treatments, fissure sealants, and simple fillings — is managed by dental therapists and general dentists, keeping appointments accessible and CDBS bulk billed. - **Moderately complex cases** — including permanent tooth restorations, extractions, and early orthodontic monitoring — are handled by Core Dental Group's experienced general dentists with a strong paediatric focus. - **Highly complex cases** — children with significant dental anxiety, developmental anomalies, special health needs, orofacial trauma, or treatment requiring sedation — are managed by or in close consultation with Core Dental Group's registered specialist paediatric dentists.

The clinical value of this model is that it eliminates the most common failure point in paediatric dental care: the gap between identification and treatment. In a practice without an integrated specialist, a general dentist who identifies a complex case must refer the family externally — introducing delays, additional costs, and the disruption of establishing care with an entirely new team. At Core Dental Group, that escalation happens internally, with full continuity of clinical records, family rapport, and treatment context.

Part 2: The Timeline — When your child should see a dentist

The first visit: earlier than most parents think

The most consequential decision most Melbourne parents make about their child's dental health is not which practice to choose — it is *when* to start. And the clinical evidence is clear: most Australian parents start too late.

The Australian Dental Association recommends that children have their first dental visit by their first birthday or within six months of their first tooth erupting. Yet survey data shows that 40% of Australian parents believe age two is acceptable for a first dental visit, 20% believe age three is fine, and 10% think age four or older is appropriate — leaving only 25% who correctly identify age one or younger as the right time.

The consequences of this gap are measurable. There were close to 88,600 hospitalisations for dental conditions that potentially could have been prevented with earlier treatment in 2023–24. Many of these involve children whose preventable decay escalated — through delayed or absent dental care — to the point of requiring general anaesthesia.

The psychological stakes are equally significant. Research published in *Healthcare* (MDPI, 2021) found a statistically significant correlation between dental fear and age at first visit. The correlation between dental fear and age at first visit ($r = -0.36$, $p < 0.01$) and dental fear and frequency of visit ($r = -0.65$, $p < 0.01$) were statistically significant. The regression analysis showed that both variables predicted 44.4% of the dental fear in the child. In conclusion, the age of initiation to the paediatric dentist (before 2 years) and the periodic revisions (every 6 months or every year) could protect the child from dental fear.

Early dental visits are not merely about examining teeth — they are a direct anxiety-prevention strategy. The longer a child waits for their first appointment, the higher the statistical probability that dental anxiety will develop. Children without dental visit experience (OR=1.37) and children with caries experience (OR=1.18) had higher odds of experiencing dental fear and anxiety compared to those with dental visit experience or caries-free status.

At Core Dental Group, children are welcomed from around age two for their first appointment — and earlier if a tooth has already appeared or if parents have concerns. This aligns with the ADA's clinical

intent: normalise dental attendance before problems emerge.

The age-by-age dental milestone map

Understanding what is happening in your child's mouth at each developmental stage — and what your dentist should be doing about it — is the foundation of proactive oral health care.

| Developmental Stage | Age Range | Key Dental Events | Recommended Action | |---|---|---|---| | Pre-teething | Birth–6 months | Teeth forming beneath gums | Gum wipes; establish dental home | | First tooth eruption | 6–12 months | First baby tooth appears | **Book first dental visit now** | | Primary dentition | 12 months–3 years | All 20 baby teeth erupt | Six-monthly check-ups; fluoride varnish | | Early mixed dentition | 6–8 years | First permanent molars; front teeth shed | Fissure sealants; orthodontic screening | | Late mixed dentition | 9–12 years | Remaining baby teeth shed | Space monitoring; X-rays | | Permanent dentition | 12–18 years | Full adult dentition; wisdom teeth forming | Continued six-monthly care; wisdom tooth monitoring |

The six-year molars deserve particular attention: they are the first permanent teeth to erupt, they arrive without any preceding baby tooth as a visual marker, and they are among the most decay-prone teeth in the mouth due to their deep fissures. Many parents don't realise these teeth have arrived — and therefore don't seek the fissure sealant protection that could prevent years of restorative treatment.

*(For the complete age-by-age guide including what your dentist assesses at each stage, see: **When Should My Child First Visit the Dentist? Age-by-Age Dental Milestones for Melbourne Parents**.)*

Part 3: The First Visit — What to expect and how to prepare

Preparing your child: language is a clinical tool

The words you use in the days before your child's first dental appointment shape their expectations — and potentially their dental psychology for years to come. Evidence-based guidance from Australian paediatric dental practitioners is clear: do not use words that may instil fear, such as "needles," "pain," or "hurt." Avoid negative stories. Do not use the dentist as a threat. Even if you carry your own dental anxiety, try not to show it — children are highly attuned to parental emotional cues.

Instead, frame the visit positively: the dentist will "count your teeth" and "check how strong they are." Practise counting teeth at home with a spoon as a pretend dental mirror. For children who benefit from visual preparation, positive dental storybooks or age-appropriate videos of dental visits can reduce anticipatory anxiety significantly.

Practical logistics matter too: book morning appointments when children are calmer and more cooperative, avoid scheduling around nap times for toddlers, and bring a comfort object for young children. When you call to book, explicitly state that you wish to use your child's CDBS entitlement — this allows Core Dental Group to verify eligibility, prepare consent documentation, and confirm which services are covered before you arrive.

The Tell-Show-Do technique: the gold standard in paediatric behaviour management

Before any instrument enters your child's mouth at Core Dental Group, clinicians use the **Tell-Show-Do (TSD)** technique — the most widely adopted non-pharmacological behaviour management approach in paediatric dentistry. Research indicates that TSD achieves an 80% treatment success rate, suggesting that explaining procedures to children and demonstrating them before performing significantly contributes to treatment success.

In practice, the clinician will: (1) **Tell** your child what they are going to do using age-appropriate, non-threatening language; (2) **Show** them the instrument on their own hand or a model; and (3) **Do** the procedure only once the child has had the opportunity to understand and accept it. This

three-stage approach is calibrated to the child's developmental stage — a two-year-old requires far simpler language and a much shorter "tell" phase than an eight-year-old.

The knee-to-knee examination for infants and toddlers

For children aged six to approximately 24 months, the standard dental chair is not the appropriate examination setting. Core Dental Group uses the **knee-to-knee examination technique**, a clinically recognised approach where the child sits in the parent's lap facing them, then leans back into the dentist's lap for examination. The dentist holds and supports the child's head while the parent is free to hold the child's hands. This technique typically lasts no more than 15 minutes and allows for a complete visual examination plus preventive treatments like fluoride varnish — all while maintaining the child's sense of security through physical proximity to their parent.

What the first examination actually assesses

A first dental visit at Core Dental Group is not a cursory visual inspection — it is a structured clinical assessment covering:

- **Teeth:** Eruption sequence, decay status (including early white-spot lesions), enamel defects, developmental anomalies - **Gums and soft tissue:** Inflammation, frenulum attachment, signs of infection - **Bite and occlusion:** Early indicators of crossbite, open bite, overbite, or underbite - **Jaw development:** Growth patterns, symmetry, spacing for incoming permanent teeth - **Oral habits:** Evidence of thumb-sucking, dummy use, or mouth-breathing effects on palatal arch shape

The clinician also takes a full medical history — including current medications, known allergies, and any systemic conditions — and provides parents with take-home guidance on brushing technique, fluoride toothpaste selection, feeding practices, and the management of any oral habits.

*(For the complete step-by-step walkthrough of what happens at a first visit, including the consent process and take-home care plan, see: **Your Child's First Dental Visit at Core Dental Group Melbourne: A Step-by-Step Guide for Parents**.)*

Part 4: The CDBS — Your child's government-funded dental entitlement

What the CDBS is and why most eligible families don't use it

The Child Dental Benefits Schedule (CDBS) is the single most significant government initiative available to Melbourne families for children's dental care — and yet research consistently shows that most eligible families never access it. The Child Dental Benefits Schedule (CDBS) provides basic dental services to eligible children aged 0 to 17 years.

The scheme operates through Medicare, not private health insurance. The CDBS allows eligible children to access general dental treatment at both public and private dental clinics. At most dental clinics, this treatment will be bulk-billed. When a practice like Core Dental Group bulk bills CDBS services, the family pays nothing out of pocket for covered treatments.

The 2025–2026 benefit cap: current figures

The CDBS cap is indexed annually on 1 January. You can only claim benefits for up to $1,132 for each eligible child if 2025 is year one of the 2 calendar year period, or up to $1,158 for each eligible child if 2026 is year one of the 2 calendar year period.

The cap amount is indexed yearly on 1 January. The increase in cap amount will only apply to a child or teenager who gets their first eligible service in that year.

You can use the full amount up to $1,158 for each eligible child in the first calendar year. Unused funds do not roll over indefinitely — if you don't use the full amount within the two calendar years, you cannot

use the remaining funds and must wait for a new two-year cover period to start.

Eligibility: the three criteria

To be eligible, a child must be aged 0 to 17 years for at least one day of the calendar year; eligible for Medicare on the day of service; and receive, or be part of a family receiving, certain Australian Government payments. Eligibility is assessed at the beginning of each calendar year and is valid for the entire year.

The most common qualifying payment is Family Tax Benefit Part A. The CDBS provides individual benefits for a range of services including exams, x-rays, fillings and root canals (it excludes orthodontic or cosmetic dental procedures), for children aged 0–17 years whose parents receive Family Tax Benefit Part A or a relevant Australian Government payment. Families receiving *only* FTB Part B do not qualify — eligibility is linked specifically to FTB Part A.

What is and is not covered

CDBS-covered services include fissure sealing, fillings, root canals, extractions, and partial dentures. Examinations, X-rays, professional cleaning, and fluoride treatments are also covered. The CDBS doesn't cover orthodontic, cosmetic dental work, or dental services provided in hospital.

This exclusion of hospital-based dental services matters clinically: children whose preventable decay escalates to the point of requiring general anaesthesia in a hospital setting lose access to CDBS funding entirely — one of the strongest arguments for early preventive care.

How to claim bulk billing at Core Dental Group: zero out-of-pocket

Bulk billing under the CDBS means the practice claims directly from Medicare on your behalf. If the dentist bulk bills, you don't need to pay or claim. At Core Dental Group, CDBS-eligible children are seen under a full bulk billing arrangement — zero gap, zero upfront payment, zero surprise bill.

The process is straightforward:

1. **Confirm eligibility** before booking via myGov (History & Statements → Child Dental Benefits Schedule) or by calling Medicare on 132 011. When you book an appointment, say you want to use CDBS. Check how close you are to the balance cap limit.

2. **Notify Core Dental Group at booking** that you wish to use your child's CDBS entitlement — this allows the team to verify eligibility, prepare consent documentation, and confirm covered services in advance. 3. **Attend and sign the consent form** — the bulk billing consent form is the legal instrument by which you assign your child's Medicare benefit directly to Core Dental Group. 4. **Treatment is delivered and Core Dental Group claims on your behalf** — electronically, at the point of service. It is the responsibility of the billing/claiming dental provider that the patient or the patient's parent/guardian/carer is informed of the likely costs before commencing any CDBS service, including examinations, diagnostic services, and emergency treatment.

*(For the complete step-by-step claiming guide including what to bring, what to say, and how the two-year cap period works, see: **How to Claim CDBS Bulk Billing at Core Dental Group Melbourne: A Parent's Step-by-Step Claiming Guide**.)*

CDBS vs. private health insurance: the strategic question

Many Melbourne parents with private health insurance assume their fund covers everything and overlook their CDBS entitlement. This is a costly error. The two funding streams cannot be claimed simultaneously for the same service — but they can be deployed strategically across different services.

The optimal approach for eligible families with private health insurance is: use CDBS bulk billing at Core Dental Group for all CDBS-covered services (check-ups, X-rays, cleans, fillings, fissure sealants,

extractions) until the cap is exhausted, then use private health insurance for services outside the CDBS scope — orthodontic treatment, custom mouthguards, or any treatment required after the CDBS cap is reached. Provided dentists are registered with the Dental Board of Australia and hold a Medicare provider number, they can provide services under the CDBS, but before any treatment commences, the eligibility of the child for the CDBS must be confirmed and the remaining amount of funds in their allocation must also be checked. Core Dental Group does this automatically for all CDBS patients at every appointment.

*(For a detailed financial comparison including worked cost scenarios, see: **CDBS Bulk Billing vs. Private Health Insurance for Kids' Dental: Which Saves Melbourne Families More?**.)*

Part 5: Why Baby Teeth Matter — The clinical case for prevention

The misconception that costs children their smiles

"Do we really need to treat this tooth? It's just going to fall out anyway." This question is one of the most clinically consequential misconceptions in paediatric health — and it is asked in dental practices across Melbourne every week.

Baby teeth are not placeholders for something more important. They *are* something important. The first primary molars — the teeth most critical for chewing and space maintenance — don't shed until approximately age nine to eleven. The second primary molars remain until age ten to twelve. A child's primary molars serve active dental function for a decade or more. Treating decay in a six-year-old's molar as unimportant because "it will fall out" ignores the fact that tooth may need to function for another four to six years.

The four critical functions baby teeth serve

1. Space maintenance for permanent teeth

Each primary tooth acts as a biological space maintainer, holding the arch length required for the permanent tooth developing beneath it. When a baby tooth is lost early because of decay or trauma, adjacent teeth drift into the gap — reducing the space needed for the permanent successor and frequently creating an orthodontic crowding problem that requires years of treatment to correct.

Research published in *The Angle Orthodontist* demonstrates this with population-level data: a study of 225 school children showed that premature loss of primary canines and molars resulted in the need for orthodontic treatment when no space maintenance was utilised. In almost all cases of early tooth loss, some decrease of arch length is to be expected, and this loss occurs within the first six months after the tooth is lost.

The tooth most commonly implicated is the second primary molar. When it is lost early, the large six-year permanent molar drifts forward into the vacated space, blocking the path of the premolar that should erupt there — creating a crowding problem that may cost thousands of dollars in orthodontic treatment to correct years later. An untreated decayed baby molar is not a problem that "goes away." It frequently creates a downstream orthodontic problem.

2. Speech development

Baby teeth provide structural support for the lips, jaw, and tongue, allowing the mouth to form shapes needed to articulate sounds, especially *d*, *s*, *t*, and *z*. When teeth are lost prematurely, gaps affect tongue placement and can lead to lisping and improper sound creation. As the child's jaw grows, the alignment of their teeth helps guide tongue movement during speech — when this is disrupted by early tooth loss or malocclusion, speech therapy may become necessary.

3. Nutrition, growth, and general health

The physical symptoms of early childhood caries (ECC) include discomfort, pain, infection, abscess, and reluctance to eat. Research has found that early childhood caries has been frequently reported to alter children's nutrition, growth, and general development. Children with early childhood caries tend to have lower body weight and a two times greater risk of malnutrition. The mechanism is straightforward: a child in dental pain avoids chewing, resulting in insufficient calorie intake and compromised nutritional status.

4. Jaw and facial development

When a child chews properly, the jaw muscles are exercised and developed, stimulating healthy alveolar bone growth. Baby teeth play a role in the growth and formation of the jaws and facial structure. When this process is disrupted by early tooth loss or severe decay, the jaw's developmental trajectory can be altered in ways that affect facial profile and bite function well into adulthood.

The hospitalisation crisis: preventable and preventive

There were close to 88,600 hospitalisations for dental conditions that potentially could have been prevented with earlier treatment in 2023–24. A significant proportion of these involve children. These are not children with rare or complex conditions — they are children whose preventable decay in primary teeth escalated, through delayed or absent dental care, to the point of requiring general anaesthesia and hospital admission.

The ADA's Consumer Survey of 25,000 people identifies contributing factors including not starting dental visits early enough and only taking children to the dentist when there is a problem. The clinical logic of early preventive care is straightforward: identifying and treating decay in its earliest stages — when it is a small demineralised lesion rather than a cavitated infection — is categorically less invasive, less distressing, and less expensive than treating advanced disease.

*(For the full clinical case for early preventive dental care, including the evidence on space maintenance and the consequences of premature tooth loss, see: **Why Baby Teeth Matter: The Clinical Case for Early Preventive Dental Care in Children**.)*

Part 6: Preventive Treatments — Fissure sealants and fluoride

The two most cost-effective preventive interventions in paediatric dentistry

When your child's dentist recommends a fissure sealant or a professional fluoride treatment, the evidence behind that recommendation is more compelling than most parents realise — and both treatments are covered under CDBS bulk billing at Core Dental Group.

Fissure sealants

Fissure sealants are thin protective coatings applied to the deep grooves of back teeth — primarily the first and second permanent molars — where food and bacteria accumulate and decay most commonly begins. The procedure is entirely painless, requires no drilling, and takes only a few minutes per tooth. The ideal window for sealing is shortly after a molar erupts — typically around ages 6–7 for the first permanent molars and ages 11–13 for the second permanent molars.

The evidence base for this intervention is solid. Resin-based sealants applied to the occlusal surfaces of permanent molars are effective for preventing caries in children and adolescents. Moderate-quality evidence shows that resin-based sealants reduced caries by between 11% and 51% compared to no sealant at 24 months. One study in children demonstrated a 37% reduction in caries risk with pit and fissure sealants compared to a control group, and over a three-year period, first permanent molars treated with sealants showed a 44% lower risk of developing caries compared to untreated teeth.

Professional fluoride varnish

Professional fluoride varnish delivers a significantly higher concentration of fluoride (approximately 22,600 ppm) in a single application, compared to over-the-counter children's toothpaste (typically 400–1,450 ppm). This creates a fluoride reservoir in the tooth surface that continues to remineralise enamel over weeks. The application takes minutes and is well-tolerated even by young children.

The evidence is compelling: there is approximately 37% caries reduction in primary dentition and 47% in permanent dentition associated with fluoride varnish use. The US Preventive Services Task Force gave a Grade B evidence rating to fluoride varnish use in all children from birth through age five years — and the American Academy of Pediatrics and American Academy of Pediatric Dentistry both endorse it for caries prevention.

The risk-based approach

Neither fissure sealants nor professional fluoride treatments are recommended uniformly for every child at every visit. Core Dental Group's paediatric clinicians use a structured caries risk assessment to guide these decisions, drawing on factors including dietary patterns, oral hygiene quality, fluoride exposure, previous caries history, tooth morphology, eruption stage, and medical history. This is the clinical rationale for early and regular dental visits — not to find problems, but to assess risk before problems develop.

*(For the complete evidence review including the Cochrane evidence on sealants, the fluoride safety data, and how Core Dental Group makes risk-based recommendations, see: **Fissure Sealants and Fluoride Treatments for Kids: Are They Worth It? A Melbourne Parent's Guide**.)*

Part 7: At-Home Oral Hygiene — Age-appropriate guidance

The daily routine that makes or breaks dental outcomes

No clinical intervention — however well-executed — can fully compensate for a home oral hygiene routine that constantly undermines it. Around 4 in 10 (43%) of children aged 5–14 years had a moderate accumulation of plaque. The proportion of children aged 5–14 years with a moderate accumulation of plaque was lower for children who last visited the dentist for a check-up. This confirms that regular dental attendance and home hygiene are mutually reinforcing — not interchangeable.

Age-segmented brushing guide

Age	Toothpaste	Quantity	Who Brushes
Birth–17 months	No data provided	Not applicable to this product	Adult (clean damp cloth or soft brush)
18 months–5 years	Low-fluoride (400–550 ppm)	Pea-sized amount	Adult-performed
6–7 years	Standard fluoride (1,000–1,450 ppm)	Pea-sized amount	Adult-supervised
8+ years	Standard fluoride (1,000–1,450 ppm)	Pea-sized amount	Child with adult checks

A critical warning for Melbourne parents: many premium-branded "natural" or "organic" children's toothpastes are non-fluoridated. Research has found that eighteen of the twenty most expensive toothpastes studied were non-fluoridated, whilst seventeen of the twenty least expensive contained fluoride. Price is not a proxy for protection. Always check the label for fluoride concentration.

Flossing: start earlier than you think

Begin flossing as soon as two adjacent teeth are in contact with each other — for many children, this occurs in the primary molar region from around age two to three. Flossing is the only mechanism for removing plaque from between teeth, surfaces that account for a significant proportion of childhood decay.

The diet factor: frequency over quantity

Frequent consumption of food and beverages containing free sugars is the main cause of dental caries among children. Research has found that the frequency and timing of sugar consumption affects plaque acidogenicity and early childhood caries — reducing the frequency of sugar intake, not just the total amount, could prevent early childhood caries. Limit sugary foods and drinks to mealtimes, not between-meal snacks. Never put children to bed with a bottle containing milk, formula, or juice.

Melbourne's tap water: a free protective tool

Melbourne's reticulated water supply is fluoridated, making it one of the most effective and underused tools in childhood decay prevention. Almost 50% of parents do not know that tap water is better for teeth than bottled water. Encourage children to drink from the tap at home and to use the water fountain at school.

*(For the complete at-home hygiene guide including dummy and thumb-sucking management, see: **At-Home Oral Hygiene for Children: Age-Appropriate Brushing, Flossing, and Diet Guidance from Core Dental Group**.)*

Part 8: Managing Dental Anxiety — The specialist approach

The scale of the problem and why it compounds

A total of 2,895 studies were identified in a systematic review, and the pooled prevalence of dental fear and anxiety (DFA) among 2- to 6-year-old children was estimated to be 30% (95% CI = 25, 36). Dental anxiety is not a minor inconvenience — it is the primary reason Australian families delay or avoid dental appointments, and the consequences compound: missed check-ups lead to undetected decay, undetected decay leads to pain, and pain reinforces the original anxiety in a self-perpetuating cycle that can persist well into adulthood.

The childhood dental experience is a direct upstream driver of adult oral health behaviour. Around 3 in 10 people (28%) who needed to see a dental professional delayed seeing or did not see one at least once in the previous 12 months — and around 2 in 10 (18%) reported that cost was a reason for delaying or not seeing a dental professional. Dental anxiety is the other major driver of avoidance.

Evidence-based behaviour management at Core Dental Group

Core Dental Group's registered specialist paediatric dentists complete a three-year clinical doctorate that includes dedicated training in child psychology, developmental behaviour, and evidence-based behaviour management techniques. This psychological grounding is what allows them to read a child's emotional state, adapt communication in real time, and deploy structured techniques that general dentists are not formally trained in.

Tell-Show-Do (TSD) remains the gold standard non-pharmacological technique, with an 80% treatment success rate in clinical studies. **Positive reinforcement** — specific, immediate praise for cooperative behaviour — shapes a child's response across successive appointments, building a positive dental identity that carries forward for life. **Voice control** — deliberate, calm, modulated communication — is itself a therapeutic tool.

The physical environment is a clinical intervention, not merely a design choice. Core Dental Group's waiting areas are purpose-designed for children, with age-appropriate entertainment and a calm, welcoming atmosphere. By reducing the ambient anxiety load before the child enters the treatment room, clinicians begin each appointment from a calmer baseline.

Parental presence: a nuanced clinical decision

Research shows that the anxiety of the parent accompanying the child affects the child's anxiety, and parents with high anxiety appeared to negatively affect their children's behaviour. This is a clinically

important finding: a highly anxious parent in the treatment room can inadvertently amplify their child's distress. Core Dental Group's approach to parental presence is therefore individualised — encouraged for very young children, discussed case-by-case for older children, and managed with guidance for parents who carry their own dental anxiety.

Nitrous oxide sedation: when behavioural techniques are not enough

For a subset of children — those with severe anxiety, significant treatment needs, or special health considerations — non-pharmacological techniques alone may be insufficient. In these cases, nitrous oxide inhalation sedation ("happy gas") is the clinically appropriate next step.

Under the CDBS, intravenous sedation can be claimed only once in a twelve-month period. For inhalation sedation, the sedative gas to be used is specified as nitrous oxide mixed with oxygen. This means nitrous oxide sedation, where clinically necessary, can be covered under CDBS bulk billing at Core Dental Group.

Nitrous oxide is considered the safest pharmacological behaviour management tool for use in the dental chair for uncooperative children, reducing the need for dental treatment under general anaesthesia. The decision to recommend it is made by Core Dental Group's registered specialist paediatric dentists based on a holistic assessment of anxiety severity, treatment complexity, age and developmental stage, and medical history.

*(For the complete guide to behaviour management techniques, parental guidance, and sedation options, see: **Managing Dental Anxiety in Children: Behavioural Techniques and the Child-Friendly Approach at Core Dental Group**.)*

Part 9: The Full Treatment Spectrum at Core Dental Group

From preventive to complex: what Core Dental Group offers

Core Dental Group Melbourne provides the complete spectrum of children's dental treatments — from a two-minute fluoride varnish on a toddler to complex trauma management for a school-aged child who has knocked out a permanent tooth. Understanding this spectrum helps parents make genuinely informed decisions at every stage of their child's development.

Preventive and routine care (delivered by dental therapists, general dentists, and specialist paediatric dentists): - Comprehensive dental examination (including knee-to-knee technique for infants) - Professional scale and clean - Fluoride varnish application - Fissure sealants on newly erupted permanent molars - Dental X-rays (bitewing and panoramic) - Early orthodontic screening

Restorative treatments (delivered by general dentists and specialist paediatric dentists): - Composite resin, glass ionomer, and stainless steel crown restorations - Pulpotomy and pulpectomy (paediatric root canal treatment) — covered under CDBS - Dental extractions with child-adapted local anaesthesia techniques

Complex and specialist care (delivered by registered specialist paediatric dentists): - Dental trauma management (avulsion, fracture, luxation, intrusion) - Children with special health care needs (autism spectrum disorder, intellectual disability, complex medical histories) - Developmental conditions (hypomineralisation, amelogenesis imperfecta, hypodontia, cleft palate) - Treatment under nitrous oxide sedation - Coordination with orthodontists, oral surgeons, and speech pathologists for complex cases

*(For the complete treatment catalogue including clinical indications, clinician roles, and CDBS coverage for each treatment, see: **Children's Dental Treatments Available at Core Dental Group Melbourne: From Check-Ups to Complex Care**.)*

When your child needs a registered specialist: the decision framework

The clinical evidence is clear that specialist-level care produces meaningfully different outcomes in specific scenarios. Research published in the *European Archives of Paediatric Dentistry* found that paediatric dentists use rubber dam significantly more often, perform more preventive treatments in children up to age 11, take more radiographs, use local analgesia more often in younger children, and perform more restorations in children up to age 6 — compared with general dentists. The differences are most pronounced in the youngest and most vulnerable age groups.

The following scenarios represent clear clinical indications for specialist involvement at Core Dental Group:

1. **Severe or early childhood dental anxiety** — requiring dedicated psychology-informed behaviour management beyond what general practice provides 2. **Children with special health care needs** — autism spectrum disorder, intellectual disability, Down syndrome, cerebral palsy, bleeding disorders, cardiac conditions 3. **Dental trauma** — knocked-out, fractured, or intruded teeth requiring specialist knowledge of developing dentition protocols 4. **Complex developmental conditions** — hypodontia, hypomineralisation, amelogenesis imperfecta, or cleft lip and palate 5. **Treatment requiring sedation** — where nitrous oxide or referral for general anaesthesia is indicated 6. **Early orthodontic concerns** — crowding, crossbites, jaw growth discrepancies requiring specialist developmental assessment

*(For the complete clinical decision framework and the evidence on when specialist care changes outcomes, see: **Specialist Paediatric Dentist vs. General Dentist for Kids: Which Does Your Child Actually Need?**.)*

Part 10: Early Orthodontic Assessment and Sports Protection

The age-seven orthodontic screening: why it matters

The American Association of Orthodontists recommends that all children be screened by an orthodontist at age seven, because by that age a child has enough permanent teeth for a clinician to detect and potentially treat jaw or teeth alignment issues. The Australian orthodontic and paediatric dental community aligns with this evidence base.

At Core Dental Group, orthodontic screening is woven into routine paediatric dental care — not treated as a separate, later-stage referral. By age seven, two critical developmental events have occurred simultaneously: the first permanent molars have erupted (establishing the posterior bite relationship), and the upper and lower central incisors have emerged (making it possible to evaluate overjet, overbite, and midline alignment).

Dental problems related to jaw growth get worse, not better, with time. Because children are growing rapidly, they can benefit from appliances which can balance the relationship between the upper and lower jaws and develop room for erupting teeth — allowing for easier treatment later with less need for extractions or surgery.

One finding of particular clinical significance: an increased overjet greater than 5 mm in children aged 7 to 14 is associated with more than double the risk of dental trauma — reinforcing the argument for early intervention in selected cases. This connects directly to the emergency and trauma section below.

Core Dental Group clinicians assess bite classification, arch width and crowding potential, developing teeth via panoramic X-ray, oral habits affecting jaw development, and jaw symmetry. One of three outcomes results: no treatment needed; monitoring with periodic reassessment; or early interceptive treatment (space maintainers, palatal expanders, functional appliances, or Phase One braces where indicated).

CDBS note: The CDBS doesn't cover orthodontic, cosmetic dental work, or dental services provided in hospital. However, the orthodontic *assessment* conducted as part of a routine check-up, and panoramic X-rays to assess tooth development, *are* covered under CDBS bulk billing at Core Dental Group. Space maintainers — which prevent orthodontic problems from developing — are also covered as a general dental service.

*(For the complete guide to early orthodontic screening, interceptive options, and what Core Dental Group looks for, see: **Early Orthodontic Assessment for Children in Melbourne: When to Start and What Core Dental Group Looks For**.)*

Custom mouthguards: the overlooked protection

Sports-related injuries account for nearly 40% of dental injuries in Australia, yet only 36% of Australians wear a mouthguard when playing contact sport. It is estimated that a fifth of Australian children have experienced dental trauma by the time they are 14 years old.

The difference between a professionally custom-fitted mouthguard and a store-bought boil-and-bite guard is not marginal. A 2014 randomised controlled trial found that players using custom mouthguards had a concussion rate of 3.6% compared to 8.3% for those using boil-and-bite guards — a statistically significant difference across the same teams, same helmets, and same season. A 2023 meta-analysis pooling 192 studies found that mouthguards in collision sports reduced concussion incidence by 26%. Most of the underlying trials used custom-fit devices.

For children specifically, boil-and-bite guards are particularly unsuitable: their mouths are actively growing, and a guard fitted in February may not fit correctly by August. A guard that a child refuses to wear because it is uncomfortable offers precisely zero protection.

Getting a custom mouthguard at Core Dental Group is a straightforward two-appointment process: an impression or digital scan, laboratory fabrication in professional-grade EVA material, and a fitting appointment with chairside adjustments. The Victorian Department of Education's Physical and Sport Education Safety Policy notes that mouthguards can be made to allow for missing and erupting teeth and to fit over orthodontic wires — something no boil-and-bite guard can achieve.

*(For the complete guide to sports mouthguard protection, the clinical evidence, and which sports require protection under Victorian guidelines, see: **Custom Mouthguards for Children Playing Sport in Melbourne: Why a Fitted Guard Outperforms a Store-Bought One**.)*

Part 11: Dental Emergencies — What to do right now

The most time-critical decision in children's dentistry

Approximately 30% of children will experience dental trauma at some stage. Yet most Melbourne parents have no practised plan for what to do. The most vital factor in managing dental trauma is time, and prompt treatment is extremely important.

For a knocked-out permanent tooth, the research is unambiguous: of teeth replanted within one hour of avulsion, 64% remained in their sockets at five-year follow-up, compared to 71% of all lost teeth having an extra-alveolar time of more than one hour. Every additional minute a permanent tooth spends outside the mouth meaningfully reduces its chance of survival.

Emergency action protocols by injury type

Toothache: Rinse with warm water, gently floss to remove trapped debris, apply a cold compress externally, administer age-appropriate paracetamol or ibuprofen (do not place aspirin on gum tissue), and call Core Dental Group immediately for same-day triage.

Dental abscess: Signs include severe pain, fever, swelling, and a pimple-like bump on the gums. This is not a "wait and see" situation. Dental infections can lead to life-threatening illness. If your child has facial swelling spreading to the eye, neck, or floor of the mouth, difficulty swallowing or breathing, or high fever combined with dental pain, go directly to hospital emergency.

Fractured or chipped tooth: Collect all tooth fragments and store in milk or saline. Rinse the mouth gently, apply a cold compress, and call Core Dental Group for same-day assessment. A fracture exposing the nerve is a true dental emergency requiring urgent pulp treatment.

Knocked-out permanent tooth — the most time-critical emergency:

| Step | Action | Why It Matters | |---|---|---| | Find the tooth | Handle only the crown, never the root | Root surface cells are critical for reattachment | | Rinse if dirty | Cold running water for 10 seconds only | Removes debris without stripping PDL cells | | Reimplant immediately | Gently push back into socket in correct orientation | Every minute out of socket damages viability | | If reimplantation not possible | Store in cold milk, saline, or inside the child's cheek | Milk maintains PDL cell viability for up to 60 minutes | | Never store in water | Water is hypotonic and rapidly destroys PDL cells | — | | Call Core Dental Group immediately | Phone triage begins the moment you call | Clinician guides you whilst you travel |

Critical distinction: Baby teeth should NOT be reimplanted. Call Core Dental Group for guidance — specialist assessment of the underlying permanent tooth bud via X-ray is still required.

Melbourne's emergency resources

- **Core Dental Group Melbourne** — same-day emergency appointments with phone triage; clinician (not receptionist) assesses the situation and provides real-time first-aid guidance - **Royal Children's Hospital Emergency Department** — 50 Flemington Road, Parkville VIC 3052 — (03) 9345 5522 — 24 hours, 7 days - **Royal Dental Hospital of Melbourne** — 720 Swanston Street, Carlton VIC 3053 — (03) 9341 1000

Go directly to hospital and call 000 if your child has facial swelling extending to the neck or eye, difficulty breathing or swallowing, uncontrolled bleeding, or loss of consciousness following head trauma.

*(For the complete emergency guide including CDBS coverage for emergency treatments and what to expect at a Core Dental Group emergency consultation, see: **Children's Dental Emergency in Melbourne: What to Do When Your Child Has a Toothache or Knocked-Out Tooth**.)*

Frequently Asked Questions

Q: At what age should my child first see a dentist in Melbourne?

The Australian Dental Association recommends a first dental visit by age one or within six months of the first tooth erupting — whichever comes first. At Core Dental Group, we welcome children from around age two for their first appointment, and earlier if a tooth has already appeared or if parents have concerns. Research shows that initiating dental visits before age two significantly reduces the likelihood of dental anxiety developing. (See our guide: *When Should My Child First Visit the Dentist? Age-by-Age Dental Milestones for Melbourne Parents*.)

Q: What is the difference between a specialist paediatric dentist and a general dentist who treats children?

A registered specialist paediatric dentist holds a legally protected title under Australian law, requiring completion of an undergraduate dental degree, a minimum of two years in general practice, and a three-year full-time clinical doctorate in paediatric dentistry — a minimum of ten years of total training.

Specialist titles are protected under the National Law. A general dentist does not hold specialist registration. The clinical difference is most pronounced for children with severe dental anxiety, developmental conditions, special health needs, dental trauma, or complex treatment requiring sedation.

Q: How much does the CDBS cover, and how do I access it at Core Dental Group?

You can claim up to $1,132 for each eligible child if 2025 is year one of the 2 calendar year period, or up to $1,158 for each eligible child if 2026 is year one of the 2 calendar year period. At Core Dental Group, CDBS-eligible children are seen under full bulk billing — zero out-of-pocket cost. Simply tell the team you wish to use CDBS when booking, bring your child's Medicare card, and sign the bulk billing consent form at the appointment. Core Dental Group claims directly from Medicare on your behalf. (See our guide: *How to Claim CDBS Bulk Billing at Core Dental Group Melbourne: A Parent's Step-by-Step Claiming Guide*.)

Q: Does my child need to see a specialist paediatric dentist, or will a general dentist do?

For the majority of Melbourne children with straightforward dental needs, a skilled general dentist or dental therapist provides excellent, evidence-appropriate care. A registered specialist paediatric dentist is specifically indicated for children with severe dental anxiety, dental trauma, developmental anomalies, special health care needs, or treatment requiring sedation. Core Dental Group's integrated model means this determination is made internally — families don't need to self-triage or navigate external referrals. (See our guide: *Specialist Paediatric Dentist vs. General Dentist for Kids: Which Does Your Child Actually Need?*.)

Q: Are fissure sealants and fluoride treatments covered under CDBS?

Yes. CDBS-covered services include fissure sealing, fillings, root canals, extractions, and partial dentures. Fluoride treatments and examinations are also covered. At Core Dental Group, both fissure sealants and professional fluoride varnish can be provided with zero out-of-pocket cost for CDBS-eligible children. (See our guide: *Fissure Sealants and Fluoride Treatments for Kids: Are They Worth It? A Melbourne Parent's Guide*.)

Q: What should I do if my child knocks out a tooth?

If it is a permanent tooth: handle only the crown (not the root), rinse briefly under cold water, reimplant immediately if possible, or store in cold milk or saline. Call Core Dental Group immediately — phone triage begins the moment you call. Time is the critical variable: teeth reimplanted within 30 minutes have a significantly higher chance of survival. If it is a baby tooth, do not reimplant — call Core Dental Group for specialist assessment of the underlying permanent tooth bud. (See our guide: *Children's Dental Emergency in Melbourne: What to Do When Your Child Has a Toothache or Knocked-Out Tooth*.)

Q: Can I use both CDBS and private health insurance for my child's dental care?

Not for the same service. Patients with private health insurance cannot claim a benefit from both the private health insurer and the CDBS for the same dental service. However, the two can be deployed strategically: use CDBS bulk billing at Core Dental Group for all CDBS-covered services until the cap is exhausted, then use private health insurance for services outside the CDBS scope (orthodontics, custom mouthguards, or treatments after the cap is reached). (See our guide: *CDBS Bulk Billing vs. Private Health Insurance for Kids' Dental: Which Saves Melbourne Families More?*.)

Q: When should my child have an orthodontic assessment?

The American Association of Orthodontists recommends that all children be screened by age seven, when a mix of baby and permanent teeth allows clinicians to assess bite development and jaw growth with meaningful accuracy. At Core Dental Group, orthodontic screening is integrated into routine

paediatric dental check-ups — it is not a separate, later-stage referral. Most first assessments result in a "monitor and recheck next year" plan rather than immediate treatment. The assessment itself, as part of a routine check-up, is covered under CDBS bulk billing. (See our guide: *Early Orthodontic Assessment for Children in Melbourne: When to Start and What Core Dental Group Looks For*.)

Key Takeaways

1. **Start early.** The ADA recommends a first dental visit by age one or within six months of the first tooth. Research shows that starting before age two significantly reduces the risk of dental anxiety developing — and that children without dental visit experience have 37% higher odds of dental fear.

2. **Understand who is treating your child.** Australia's three-tier paediatric dental workforce — dental therapists, general dentists, and registered specialist paediatric dentists — has meaningfully different qualifications, scope, and legal protections. Specialist titles are protected by law under the National Law. Core Dental Group's integrated model ensures every child is matched to the right clinician.

3. **Baby teeth are not expendable.** Primary molars serve active dental function for a decade. Premature loss from untreated decay creates orthodontic crowding problems that may cost thousands to correct — and the arch length loss occurs within the first six months of tooth loss.

4. **CDBS bulk billing is zero out-of-pocket.** Eligible children (aged 0–17, Medicare-enrolled, with qualifying government payments) can access up to $1,132–$1,158 in dental benefits over two calendar years at no cost at Core Dental Group. Most eligible families do not use this entitlement — a costly oversight.

5. **Prevention is categorically less expensive than treatment.** Fissure sealants reduce caries risk by 37–44% over three years. Professional fluoride varnish reduces caries by 37–47% in primary and permanent dentition respectively. Both are covered under CDBS bulk billing and cost nothing out of pocket at Core Dental Group for eligible children.

6. **Dental anxiety is a clinical problem with clinical solutions.** The 30% prevalence of dental fear and anxiety in children aged 2–6 is not inevitable. Specialist paediatric dentists are trained in evidence-based behaviour management — Tell-Show-Do, positive reinforcement, environmental design, and nitrous oxide sedation where indicated — that general dentists are not formally trained to deliver.

7. **Dental emergencies require a practised plan.** 30% of children will experience dental trauma. For a knocked-out permanent tooth, every minute outside the mouth matters. Know the protocol, store Core Dental Group's number, and know when to go directly to the Royal Children's Hospital or Royal Dental Hospital of Melbourne.

8. **Orthodontic screening at age seven is a clinical standard, not a marketing message.** Early assessment identifies developing problems when they are most efficiently corrected — and the assessment itself is covered under CDBS bulk billing at Core Dental Group.

Conclusion: The integrated model that changes outcomes

The defining challenge in children's oral health in Australia is not a lack of clinical knowledge — it is the gap between what the evidence recommends and what families actually do. Children present to dental practices for the first time with advanced decay. Eligible families leave CDBS entitlements unclaimed. Parents misunderstand the significance of baby teeth. Dental anxiety goes unmanaged until it becomes avoidance. Orthodontic problems that could have been intercepted at age seven become complex, expensive treatments at age fourteen.

Core Dental Group's model is built to close every one of these gaps. The integrated multi-disciplinary team — dental therapists, general dentists, and registered specialist paediatric dentists working under one roof — means that every child receives care matched to the complexity of their needs, without the friction of external referrals or the disruption of changing practices. CDBS bulk billing is available for all eligible children, with zero out-of-pocket cost and no administrative burden on families. And the clinical environment — purpose-designed for children, staffed by clinicians trained in paediatric psychology — is itself a therapeutic intervention that builds the positive dental identity children carry forward for life.

Good oral health in childhood is not merely about teeth. Good oral health in children can also indicate good oral health in adults. The investment made in a child's dental health in these formative years — the early first visit, the six-monthly check-up, the fissure sealant on the newly erupted molar, the age-seven orthodontic screen — compounds across a lifetime. The case for children's dentistry at Core Dental Group Melbourne is not simply that it is convenient or affordable. It is that it is built to get the clinical foundations right from the very beginning.

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