CLEANING, AND PREVENTIVE CARE.

Male ◯ Female ◯ Child's Date of Birth / / NHI Number

Child's First Name (legal given name) Also Known As

Child's Family Name (legal surname) Child's Middle Name(s)

Contact Address

Home Phone Work Phone Mobile Phone (Parent/Guardian)

Email Address (Parent/Guardian)

Brother's / Sister's Name/s and Date/s of Birth

Current School / Preschool

Ethnicity
Which ethnic group does this child belong to?
Tick the space or spaces that apply

- ◯ New Zealand European
- ◯ Māori
- ◯ Samoan
- ◯ Cook Island Māori
- ◯ Tongan
- ◯ Niuean
- ◯ Chinese
- ◯ Indian
- ◯ Fijian
- ◯ South East Asian
- ◯ Middle Eastern
- ◯ Latin American / Hispanic
- ◯ African
- ◯ Tokelauan
- ◯ Other (Such as Dutch, Japanese etc.)

NZ Residency Status

◯ New Zealand Citizen
*Please include a copy of your **child's** Passport or birth certificate*

◯ Other
*Please include a copy of **parent/guardian's** Passport(s) photo page(s), including relevant Visa details page(s).*

- and -

Please include one of the following:
- *A copy of your **child's** Passport photo page, including relevant Visa details page. **or***
- *A copy of your **child's** birth certificate.*

☐ I have enclosed the above requested documents with this form.

For more information on eligibility please visit www.moh.govt.nz/eligibility, or call 0800 825583

Office use only:

MEDICAL HISTORY

Some medical conditions and some medicines can affect dental care. To help us take good care of your child and ensure their safety please tick if your child has had, or is suffering from any of the following:

Rheumatic Fever ◯ Asthma ◯ Latex Allergy ◯ Bleeding Conditions ◯
Heart Conditions ◯ Epilepsy ◯ Diabetes ◯ None of the above ◯

Current Medications & Other Conditions/ Allergies

Comments

Permission to contact your Doctor/Practice if necessary ◯ Yes ◯ No

Doctor/Practice Name Doctor/Practice Number

Please alert us if there are changes to any of the above.

CONSENT FOR SERVICES PROVIDED

☑ I **AGREE** to this child receiving regular:
- Examinations and dental xrays as required
- Cleaning and scaling
- Fissure Sealant
- Fluoride Varnish

I understand that I have the right to change this consent at any time.
Please ring 0800 TALKTEETH (0800 825 583)

Any additional treatments will require further consent.

Comments

Print Family Name (Parent/Guardian) Today's Date day / month / 20 year

Print First name (Parent/Guardian)

Signature (Parent/Guardian if child under 16yrs) Relationship to Child

DO NOT CONSENT

☒ I **DO NOT AGREE** to this child receiving dental services from the Auckland Regional Dental Service.

Print Family Name (Parent/Guardian) Today's Date day / month / 20 year

Print First name (Parent/Guardian)

Signature (Parent/Guardian if child under 16yrs) Relationship to Child:

USE FLUORIDATED TOOTHPASTE

BRUSH TEETH AT LEAST TWICE A DAY

FLOSS ONCE PER DAY

CHOOSE SUGAR-FREE SNACKS AND DRINKS

CHOOSE WATER FIRST

Please write any comments for the Therapist here

Office Use:

PLEASE FILL IN AND RETURN THIS FORM TO THE SCHOOL DENTAL CLINIC or SCHOOL OFFICE

The information you give us about your child will be kept by the Auckland Regional Dental Service and may be shared with other health professionals. Use of and access to the information is covered by the Health Information Privacy Code. If you want to see this information or correct any details contact:

(09) 839 0565

Auckland Regional Dental Service

Private Bag 93-115, Henderson 0650, Auckland

Website: www.ards.co.nz

Email: ards@waitematadhb.govt.nz

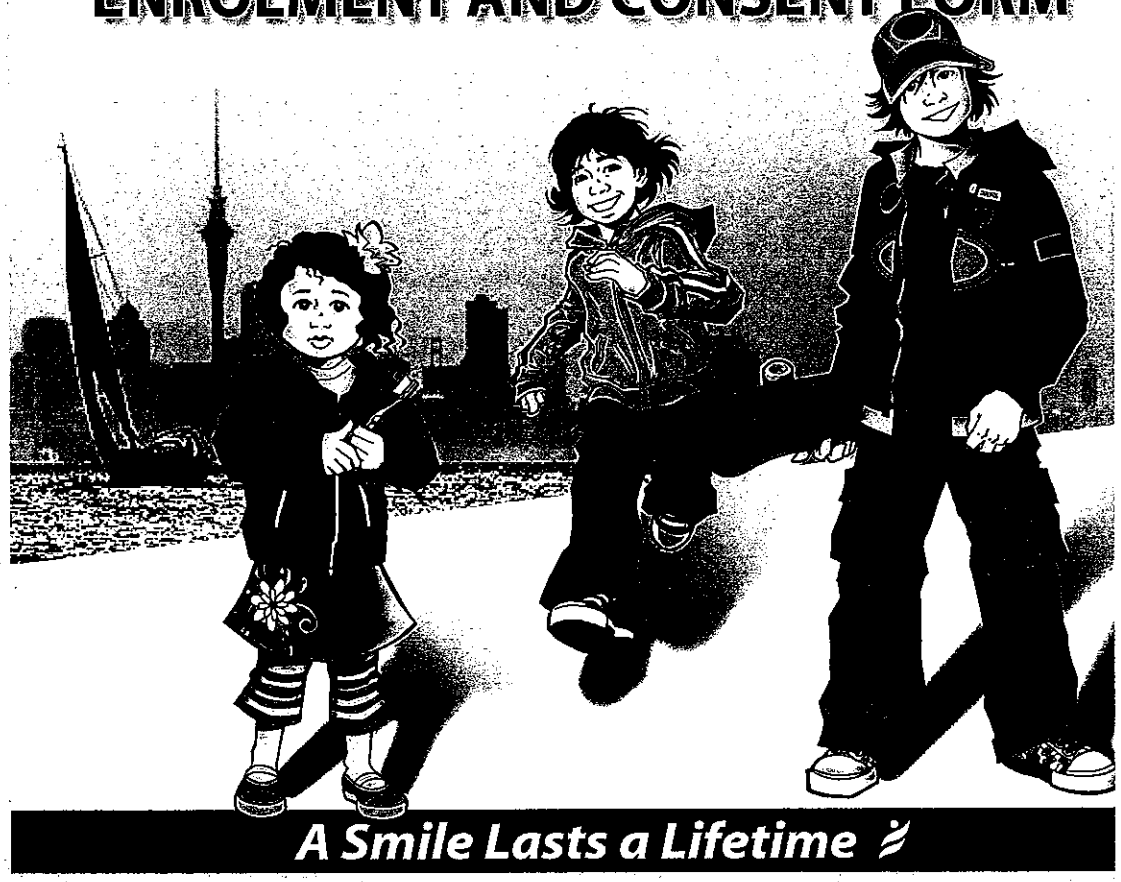
ARDS

ENROL YOUR CHILD FOR FREE

Auckland Regional

Free *Community Dental Service*

ENROLMENT AND CONSENT FORM



A Smile Lasts a Lifetime