LAKES DISTRICT HEALTH BOARD

COMMUNITY DENTAL SERVICE ENROLMENT FORM

Please complete and return this form to your Dental Therapist as soon as possible.

Child's Name _____
(Surname) (First Name)

Address _____

_____

Date of Birth _____/_____/_____ **Gender: M / F**

Telephone: Home _____ Work _____ Mobile _____

Ethnic Group (This information is required for health statistics information only)

Maori ◯ Pacific Island ◯ European ◯

Other (please state) _____

Dental History:
Please write the name of the Dental Clinic your child last attended: _____

◯ **I CONSENT** (which means that you agree) to my child being enrolled and having **free routine dental examinations** up to the end of Year 8 (Form 2). You will be contacted after examination to give written consent before any treatment commences.

◯ **I DO NOT CONSENT** to my child being enrolled and having free routine dental examinations at the Dental Clinic.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** ___/___/____

NAME OF PARENT/GUARDIAN (please print) _____

Medical History (Some medical conditions and / or medications affect dental care)

Has your child ever had: (Tick the circle if applicable)

◯ Asthma

◯ Bleeding condition

◯ Diabetes

◯ Rheumatic Fever

◯ Hepatitis

◯ HIV/AIDS

◯ Heart Condition

◯ Epilepsy

◯ Other (please specify) _____

_____

◯ Allergy to: _____

Is your child taking any pills or medicines prescribed by a doctor? Yes ◯ No ◯

If yes, please copy the name and dosage from the label:

_____

Doctors Name: _____

Permission to contact this doctor, if necessary? Yes ◯ No ◯

Clinic Stamp

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