PARENT / GUARDIAN CONSENT FOR EXAMINATION, XRAY CLEANING, AND PREVENTIVE CARE.

Male ◯ Female ◯

Child's Date of Birth (dd / mm / yyyy)

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

Name DOB | Name DOB

Name DOB | Name DOB

Current School / Preschool

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.*

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.)

☐ 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: