|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Enrolment for Adolescent Oral Health Services**  This is not a consent to treatment form. | | | | |  |
|
|
|
| New enrolment |  | Change of dental practice |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **To be completed by agreement holder** | | | | | | |
| Name of oral health practice | | |  |  | Agreement number | |
|  | | |  |  |  | |
| We agree to provide oral health services to the patient named on this form as specified in our agreement. | | | | | | |
| Signature of agreement holder |  | Date (DD/MM/YYYY) |  | Payee number | | |
|  |  |  |  |  | |  |
| Agreement holder’s name | | |  | Local district Te Whatu Ora | | |
|  | | |  |  | | |
| Address | | | | | | |
|  | | | | | | |

|  |
| --- |
| **To be completed by legal guardian or patient** |

If Year 9 and above, give this form to the dentist you have chosen.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NHI number (mandatory) | | | | | |  |  | | | | | | | | |
|  |  | | | | |  |  |
| Patient’s last name(s) | | | | | |  | Patient’s first name(s) | | | | | | | | |
|  | | | | |  | |  | | | | | | | | |
| Date of birth (DD/MM/YYYY) | | Sex | | | | | School year | | | | | | | | | |
|  |  | Male | | Female | | |  | |  | | | | | |
| Full residential address | | | Other | | | | Telephone number (day) | | | | |
|  | | | | |  | |  | | | | | |  | |
|  | | Mobile | | | | | | |
|  | |  | | | | | | | |
|  | | Postcode | | |
|  | |  | | | |  | | | |
| Secondary school / educational institution to be attended | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |

I wish the person named above to be enrolled for oral health services with the agreement holder named.  
Patient details and clinical information may be provided on request to the local district Te Whatu Ora.

If this is a transfer between dental providers, the previous dentist may be informed that this has taken place.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  | | |
| Full name of legal guardian or patient |  | Signature of legal guardian or patient | | |
|  |  | Date (DD/MM/YYYY) | | |
|  |  |

Please return to: Te Whatu Ora, Private Bag 3015, Whanganui Mail Centre, Whanganui 4540. HP 5956  
or email [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz) April 2021