MidCentral Health

CHILD AND ADOLESCENT ORAL HEALTH
REGISTRATION FORM

BARCODE AREA

Child's name *(Family/Whanau)* .....

Child's name *(First/Ingoa)* .....

Child's Date of Birth ..... ☐ Male ☐ Female

Child's Ethnicity ..... NZ Resident: ☐ Yes ☐ No

Child's NHI number .....

Iwi/Hapu affiliation *(If applicable)* .....

Well Child Provider ..... Doctor .....

If your child has had previous dental care please indicate where:

.....

Parent/Legal Guardian names .....

Address/Kainga .....

Daytime *(Ph)* ..... *(Mobile)* .....

Email address .....

Parent/Legal Guardian's signature ..... Date .....

Alternative contact details:

Name .....

Address/Kainga .....

Daytime *(Ph)* ..... *(Mobile)* .....

Other children in the household (name):

Family/Whanau ..... First/Ingoa ..... DOB .....

Family/Whanau ..... First/Ingoa ..... DOB .....

Need Rating (Health Professional Use Only) – *(please tick)*:

- ☐ High *(appointment within a month of receipt of referral)*
- ☐ Medium *(appointment within six months of receipt of referral)*
- ☐ Low *(appointment by the age of two and a half years)*

Name/desig of health professional who completed form .....

Contact phone no. of health professional .....

ENQUIRIES CONTACT: 0800 825 583

CAOH Service Office Use Only:	*Date Registered* ..... *Date of Scheduled Apt* .....

BINDING MARGIN – NO WRITING