



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

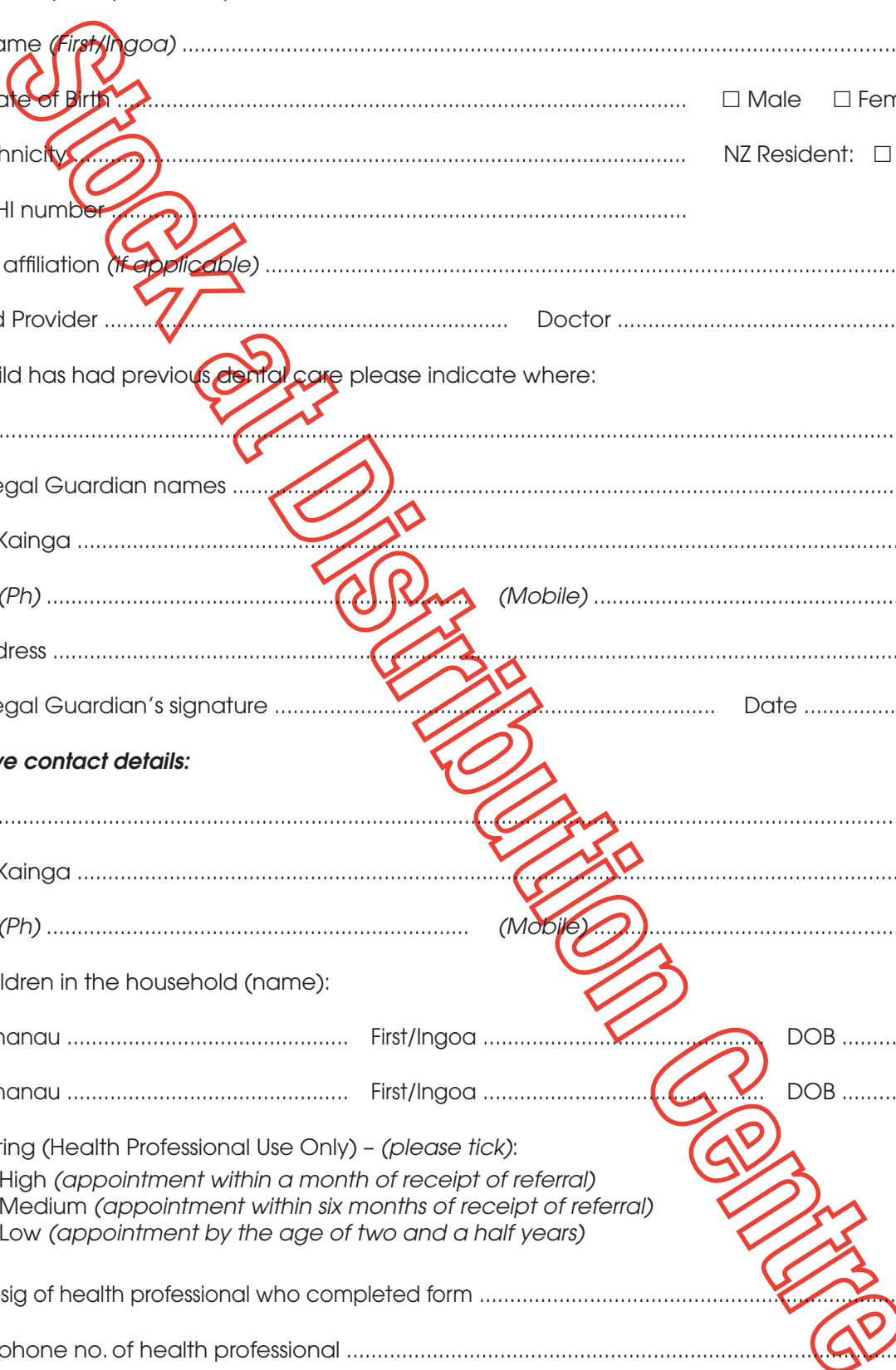
Contact phone no. of health professional

ENQUIRIES CONTACT: 0800 825 583

**CAOH Service
Office Use Only:**

Date Registered

Date of Scheduled Apt



BINDING MARGIN - NO WRITING