COMMUNITY ORAL HEALTH CONSENT FORM:

PATIENT'S DETAILS

First Name: _____ Middle Name: _____

Surname: _____ Date of Birth: _____

NHI: _____ Gender: □ Female □ Male

Address: _____

Suburb: _____Town/City: _____ Post Code:_____

Home Ph: _____ Mobile Ph: _____

Work Ph: _____ Email Address: _____

Postal Address if Different: _____

_____

Is this Patient a New Zealand Resident? □ Yes □ No

If no, country of birth and date of entry to New Zealand: _____

_____

ETHNIC GROUP: □ NZ European □ Maori □ Pacific Island □ Asian

□ Other (specify) _____

Name(s) of Sibling(s): _____

PARENT / CAREGIVER DETAILS:

How would you prefer to be contacted? □ Telephone □ Cell phone

□ Text □ Email Parent / Caregiver alternative contact details (if applicable):

_____

ALTERNATIVE CONTACT PERSON:

Name: _____

Home Phone: _____ Mobile Phone: _____

Alternative Contact Person's Relationship to Child: _____

MEDICAL HISTORY:

THIS INFORMATION IS KEPT CONFIDENTIAL

Some medical conditions and some medicines affect dental care.

Has your child had or currently have any of the following?

Asthma	Yes / No	HIV or Hepatitis A, B or C	Yes / No
Diabetes	Yes / No	Epilepsy	Yes / No
Serious Illness	Yes/ No	Rheumatic Fever	Yes / No
Heart Condition			Yes / No

If yes, please specify: _____

Bleeding Problems Yes / No

If yes, please specify: _____

Allergies Yes / No

If yes, please describe: _____

Any other condition(s)? e.g: Visual/Hearing Impaired _____

Is your child taking any tablets or other medicines (Including herbal supplements)?

If yes, please list _____

Name of Family Doctor: _____

Can we contact your Family Doctor if necessary? Yes / No

□ **I give consent for regular dental examinations for my child, using dental x-rays to help diagnosis where necessary.**

Your Name(please print) _____

Your Relationship to Child: _____

Your Signature: _____ **Date:** _____