Patient Family Names

Patient First names

DATE OF BIRTH

Day Month Year

Male ☐ Female ☐

Street Address

Suburb Town/City

Post Code Email

Phone Work Mobile

Ethnicity - Tick all boxes that apply

☐ New Zealand European ☐ Maori Iwi/Hapu

☐ Pacific Islander

☐ Other (Please state)

Previous School / Education Institution Attended

School Year

Is this child / youth a New Zealand resident/citizen? Yes ☐ No ☐

If not, please specify

If you want your child/youth to be seen by the Community Dental Service please complete and sign the **top CONSENT section.**

If you DO NOT want your child/youth to be seen by the Community Dental Service please complete and sign the **DO NOT Consent section.**

CONSENT (AGREE)

MEDICAL HISTORY

Some Medical Conditions and some medicines can affect dental care. Please indicate by ticking the YES/NO box to the following:-

Y	N		Y	N		Y	N	
☐	☐	Rheumatic Fever	☐	☐	Asthma	☐	☐	Diabetes
☐	☐	Heart Condition	☐	☐	Epilepsy	☐	☐	Hep A, B, C
☐	☐	Bleeding Condition	☐	☐	Latex Allergy	☐	☐	HIV/Aids

Other Conditions/allergies _____

Medications being taken _____

Permission to contact doctor if necessary Yes ☐ No ☐

Doctors Name / Medical Practice: _____

Although rare, accidental injury to staff can occur during handling of used instruments. If this happens during the course of your treatment, our practice requires both patient and staff member to undertake a blood test. Do you agree to a confidential blood test?

☐ Yes ☐ No ☐ I wish to discuss this with the dentist

CONSENT FOR SERVICES PROVIDED

☐ I **AGREE** to my child/youth receiving dental examinations, dental x-rays,cleaning and scaling. I understand that I have the right to change this consent at any time.

Relationship

☐ Mother ☐ Father ☐ Legal Guardian ☐ Self (over 16 years)

Print name _____

Signed _____

Today's date _____

DO NOT CONSENT (DO NOT AGREE)

☐ **I DO NOT AGREE to my child/youth receiving regular dental examinations, dental x-rays, cleaning and scaling from Te Manu Toroa Kaupapa Maori Dental Services.**

Relationship

☐ Mother ☐ Father ☐ Legal Guardian ☐ Self (over 16 years)

Print name _____

Signed _____

Today's date _____

My declaration of entitlement and eligibility* (* = mandatory fields)

	I am entitled to enrol because I am residing permanently in New Zealand* The definition of residing permanently in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months	☐

I am eligible to enrol because:

a	**I am a New Zealand citizen** (If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below)*	☐

If you are **not a New Zealand citizen**, please tick which eligibility criteria applies to you (b–j) below:

b	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	☐
c	I am an Australian citizen or Australian permanent resident AND able to show I have been in New Zealand or intend to stay in New Zealand for at least 2 consecutive years	☐
d	I have a current work visa/permit and can show that I am legally able to be in New Zealand for at least 2 years (previous visas/permits included)	☐
e	I am an interim visa holder who was eligible immediately before my interim visa started	☐
f	I am a refugee or protected person OR in the process of applying for, or appealing refugee or protection status, OR a victim or suspected victim of people trafficking	☐
g	I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one criterion in clauses a–f above OR in the control of the Chief Executive of the Ministry of Social Development	☐
h	I am a NZ Aid Programme student studying in NZ and receiving Official Development Assistance funding (or their partner or child under 18 years old)	☐
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	☐
j	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund	☐

☐ ***I confirm** that, if requested, I can provide proof of my eligibility ☐ Evidence sighted *(office use)*

My agreement to the enrolment process*
NB. Parent or Caregiver to sign if you are under 16 years

The purpose of collection of your health information is primarily for your child's care and treatment and will remain confidential. Health information can be used for quality and health audits, training and research also.

Te Manu Toroa
Kaupapa Maori Dental Service
35E Hartford Ave, Papamoa
Phone: 07 574 0214 | Email: dtreception@temanutoroa.org.nz

Te Manu Toroa

Consent for Enrolment and Dental Examinations

0 - 18 years

Child's name: _____

NHI: _____