Health New Zealand
Te Whatu Ora

Enrolment Form Adolescent Oral Health Service

This is not a consent to treatment form

Please send completed forms to **customerservice@health.govt.nz** to process or post to Private Bag 3015, Whanganui Mail Centre, Whanganui 4540. Email is the preferred method.

New enrolment ☐ Change of Dental Provider ☐

To be completed by agreement holder

Name of Dental 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

Payee number

Agreement holder's name

District/Area

Physical address

Postal 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)

Email

Patient's last name

Patient's first name

Date of birth
(DD/MM/YYYY)

School year

Full residential address

Telephone number (day)

Mobile

Postcode

Secondary school/education 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/Area and Health New Zealand.
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