

To enrol with the Adolescent Dental Service, please complete the form below

by **FAX to 09 839 0519**

or **mail to:**

Adolescent Oral Health Co-ordination Service

Private Bag 93-115, Henderson, Auckland

Adolescent Dental Service Enrolment Form	
Contact Details:	
First Name:	
Middle Name:	
Last Name:	
Address:	
Telephone Number:	
Email Address:	
Personal Details:	
Date of Birth:	
Male or Female (please tick):	<input type="checkbox"/> Male <input type="checkbox"/> Female
Which ethnic group do you belong to? (please tick)	<input type="checkbox"/> New Zealand European <input type="checkbox"/> Tongan <input type="checkbox"/> New Zealander <input type="checkbox"/> Niuean <input type="checkbox"/> Maori <input type="checkbox"/> Chinese <input type="checkbox"/> Samoan <input type="checkbox"/> Indian <input type="checkbox"/> Cook Island Maori <input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan) Please state: _____
Other Details:	
Are you (please tick): In Year 8?	<input type="checkbox"/>
In Secondary School/College?	<input type="checkbox"/>
What Secondary School will you be attending or do you attend?	
Have you left School?	<input type="checkbox"/>
Dentists Details:	
Name of Chosen Dentist:	
Address of Chosen Dentist:	

By submitting (sending by fax or mailing) this form, you have stated that you wish the above dentist to be your dental provider. You also agree to the sharing of clinical information between local District Health Boards, Ministry of Health and, if required, a new dental provider