CHILD AND ADOLESCENT ORAL HEALTH SERVICE

MEDICAL HISTORY

BARCODE AREA

Child's name .... NHI ....

Parent/Legal Guardian name ....

Parent/Legal Guardian signature ....

Contact phone number .... Date ....

Name of family doctor ....

Doctor's phone number ....

Permission to contact family doctor if necessary: ☐ Yes ☐ No

Some medical conditions and some medicines affect dental care. Please complete the following questions.

1. Has your child ever had:

	Yes	No
• Allergies to a drug or substance	☐	☐
• Asthma	☐	☐
• Bleeding problems	☐	☐
• Diabetes	☐	☐
• HIV/Aids	☐	☐
• Heart condition	☐	☐
• Hepatitis A, B or C	☐	☐
• Kidney Condition	☐	☐
• Rheumatic Fever	☐	☐

2. Is your child taking any pills or medicines prescribed by a doctor?

   ☐ Yes ☐ No *If YES, please state the name of the drug(s) – it is usually written on the bottle & state reason for taking drug(s).*

   ....

3. Is there any other medical condition that may affect dental treatment?

   ☐ Yes ☐ No *If YES, please state the condition.*

   ....

4. Special/Developmental needs *(please state)*:

   ....

CHILD AND ADOLESCENT ORAL HEALTH

REGISTRATION FORM

BARCODE AREA

BINDING MARGIN – NO WRITING

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* ....