Cheryl Henderson
Adolescent Oral Health Facilitator
100 Heads Road
Whanganui

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Enrolment to Adolescent Oral Health Services

Please complete this letter and return in the postage paid envelope provided

Surname *(BLOCK LETTERS)*		NHI Number *(if known)* Doctor:
First name *(BLOCK LETTERS)*		Middle name *(BLOCK LETTERS)*
Date of Birth / /	Gender M / F	School Year: Area moved from:
Full residential address *(BLOCK LETTERS)*		Telephone number *(day):* Mobile:
		Email:

Which ethnic group do you belong to *(mark the spaces that apply to you)*			
	New Zealand European		Chinese
	Maori		Indian
	Samoan		Other *(please state)*
	Cook Island Maori		
	Tongan		
	Niuean		

Secondary School/ Educational institution to be attended *(if appropriate)*
Name of chosen dentist *(from attached list of contracted providers)*

I wish the person named above to be enrolled for oral health services with the dentist named

Full name of Parent / Caregiver	Signature of Parent / Caregiver

Date / /

To Dentist
Please retain this form for your records and use the information to complete your enrolment form