NGĀ PUNA O WAIŌREA
WHĀIA TE MANU MĀTAURANGA

Lumino The Dentists School Smiles Programme

FREE treatment for year 9-13* - for further information visit lumino.co.nz

Enrolment Form

First Name(s)

Surname

NHI NUMBER ☐☐☐☐☐☐☐

Date of Birth

Gender ☐ MALE ☐ FEMALE

Parent/ Guardian Name

Residental Address

Secondary School

Nationality - in which country were you born

Contact Phone Daytime

Contact Phone Night time

Mobile

Email

Consent to Enrol

I/We agree

- this information is true and correct
- to enrol with Lumino the Dentists for an oral health examination and treatment.*
- Lumino may transfer my records from my previous dental provider.
- that my personal details and treatment information to be sent to the Local District Health Board and the Ministry of Health for provider payment and clinical data collection purposes.
- the enrolled child has not visited another clinician in the last 12 months.

Signature

Date

Parent or legal guardian must sign this form if the enrolling patient is under 16 years.

*Once enrolled, your child will be entitled to free treatment until they turn 18 years of age. There is no need to re-enrol every year. Your child will remain enrolled with Lumino The Dentists, unless you request their removal. Please contact us on 09 444 0552 or schoolsmiles@lumino.co.nz if there has been any change in your child's medical history, you have moved house, your child has changed schools or you would like your child to be removed from our records.

Medical Questionnaire

Family Doctor Name

Are you presently receiving any medical treatment? ☐ YES ☐ NO

Have you any allergies that you are aware of? ☐ YES ☐ NO

Have you ever experienced excessive bleeding from dental treatment, cuts or scratches? ☐ YES ☐ NO

Any change in your general health in the past year? ☐ YES ☐ NO

Have you ever had any of the following?

☐ Rheumatic fever	☐ Heart trouble	☐ Asthma
☐ High blood pressure	☐ Arthritis	☐ Hepatitis
☐ Bronchitis	☐ Chest pains	☐ Severe headaches
☐ Thyroid problem	☐ Epilepsy	☐ Anaemia
☐ Diabetes	☐ Kidney trouble	☐ Gastric problems
☐ Cold sores	☐ Depressive illness	☐ Drug dependence
☐ Tuberculosis (TB)		

Please provide details

Have you ever taken long term medication? (If yes, please name) ☐ YES ☐ NO

Have you any allergies to medicines that you are aware of? (If yes, please name) ☐ YES ☐ NO

Are you wearing an artificial joint eg. hip joint? ☐ YES ☐ NO

Have you ever had contact with the AIDS virus or Hepatitis B virus? ☐ YES ☐ NO

Are you pregnant now? (If yes, pregancy due date) ☐ YES ☐ NO

Are there any other aspects concerning your health that you think we should know about? (If yes, please indicate) ☐ YES ☐ NO

Are you currently taking any drugs or medicines? ☐ YES ☐ NO

Does your jaw'click'or hurt? ☐ YES ☐ NO

Do you feel you grind your teeth? ☐ YES ☐ NO

Have you ever had orthodontic treatment? ☐ YES ☐ NO

Do you think you have occasional bad breath? ☐ YES ☐ NO

Do your gums ever bleed when you clean your teeth? ☐ YES ☐ NO

Additional Information