EXPLANATORY NOTE

(This note is not part of the Order, but is intended to indicate its general purport.)

This Order provides:—

(*a*) for the payment of additional subsidy in respect of single houses built for old people, and

(*b*) for the payment of subsidy in respect of two new types of building which comprise units of housing accommodation for old people.

1961. No. 122 **[C]**

HEALTH SERVICES

General Dental Services

REGULATIONS, DATED 30TH MAY, 1961, MADE BY THE MINISTRY OF HEALTH AND LOCAL GOVERNMENT UNDER THE HEALTH SERVICES ACT (NORTHERN IRELAND), 1948.

The Ministry of Health and Local Government, in exercise of the powers conferred on it by sections 11 and 80 of the Health Services Act (Northern Ireland), 1948(a), and of all other powers enabling it in that behalf, hereby makes the following Regulations:—

1. These Regulations may be cited as the Health Services (General Dental Services) (Amendment) Regulations (Northern Ireland), 1961, and shall come into operation on the 1st day of June, 1961.

2. The Health Services (General Dental Services) Regulations (Northern Ireland), 1948(b), shall be amended as follows:—

(1) In sub-paragraph (4)(*a*) of paragraph 7 of the First Schedule the words "shall thereupon notify the Committee in writing of the circumstances and" shall be omitted.

(2) For the Dental Estimate Form set out in Part II of the Fourth Schedule, there shall be substituted the Schedule to these Regulations.

Sealed with the Official Seal of the Ministry of Health and Local Government for Northern Ireland this 30th day of May, nineteen hundred and sixty-one.

(L.S.)

Wm. J. Morgan,
Minister of Health and Local Government.

(a) 1948, c. 3. (b) S.R. & O. (N.I.) 1948, No. 157.

SCHEDULE

NORTHERN IRELAND GENERAL HEALTH SERVICES BOARD

DENTAL ESTIMATE FORM

A	PATIENT'S NAME (Mr., Mrs., Miss) (*Block Letters*)	B	DENTIST'S NAME AND ADDRESS AT WHICH TREATMENT IS TO BE GIVEN (*Rubber Stamp or Block Letters*)
SURNAME			
MAIDEN NAME (if married after 5/7/1948)			
FULL CHRISTIAN NAMES (as on Medical Card)			
ADDRESS			
HEALTH SERVICE No.	YEAR OF BIRTH	DENTIST'S CODE No.	

PART I. To be completed by THE PATIENT

(*a*) I desire treatment under General Dental Services and understand that it is a condition of receiving treatment that I must attend for dental examination if required to do so.

(*b*) I have been residing continuously in Great Britain/Northern Ireland since.....

To be completed as far as applicable.

(*c*) I undertake to pay the dentist the sum of £ s. d. and I understand that the dentist may require me to pay the whole or part of this sum before proceeding with my treatment.

(*d*) To be completed by persons claiming exemption from charges.

I understand that I am making the declaration which follows for the purpose of obtaining free of charge treatment for which a charge would otherwise be made, and I further understand that persons making a false declaration will be liable to a fine not exceeding £100, or imprisonment for a term not exceeding six months, or both. I undertake to provide to the Board such documentary evidence as may be required to substantiate this declaration.

YOUNG PERSONS

(i) *Exemption from the charges for dentures and other treatment:*
Persons under 16

I declare that the patient is aged under 16 years at last birthday and was born on..... with Health Service number as shown above.

Persons 16 or over receiving full-time school education

I declare that I am in full-time attendance at.....(school) .....(address) and my Health Service number is as shown above.

(ii) *Exemption from the charge for treatment other than dentures or bridges, the relining of dentures, and the addition of teeth, bands or wires to dentures:*
Persons 16 or over and under 21

I declare that I am aged under 21 years at last birthday and was born on..... and my Health Service number is as shown above.

EXPECTANT AND NURSING MOTHERS

(iii) *Exemption from the charges for dentures and other treatment:*

I declare that I am—

(1) an expectant mother and expect my confinement on or about .....

or

(2) the mother of a child born on ..... (i.e., within twelve months of the date below) and my Health Service number is as shown above.

*Signature..... Date.....