**Twizel Medical Centre Casual Patient Information**

Please complete this form and provide one form of Identification. Payment is required at the time of your consultation.

**OFFICE USE ONLY**

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| **Title** (circle) | **Mr Mrs Miss Ms Dr** | **Assigned Sex (Circle): Male Female** **Preferred Gender: \_\_\_\_\_\_\_\_\_\_\_****Preferred Pronoun: \_\_\_\_\_\_\_\_\_\_\_** | **Yes** | **No** | **N/A** |
| **Legal Name** | **First Name:****Preferred First Name:** | **Middle Name(s):** | **Surname:** | **Yes** | **No** | **N/A** |
| **Birth Details** | **Day / Month / Year** | **Place of Birth** | **Country of Birth** | **Yes** | **No** | **N/A** |
| **Ethnicity** | **Ethnicity Details**Which ethnic group(s) do you belong to? Circle the option(s) that apply to you:**Māori Iwi: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hapu: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Cook Island Māori** **NZ European Samoan Tongan Niuean Chinese Indian****Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Yes** | **No** | **N/A** |
| **Contact Details** | **Landline / Mobile:** | **Email Address:** | **Yes** | **No** | **N/A** |
| **Usual Residential Address** | **House (or RAPID) Number and Street Name** | **Suburb / Rural Delivery** | **Town / City and Postcode** | **Yes** | **No** | **N/A** |
| **Postal Address**(If different from above) | **PO Box or House Number and Street Name**  | **Suburb / Rural Delivery** | **Town / City and Postcode** | **Yes** | **No** | **N/A** |
| **Occupation** | **Occupation:** | **Name of Employer:** | **Yes** | **No** | **N/A** |
| **Eligibility** (circle) | **NZ Citizen □****Resident Visa / Permanent Resident □** | **Work Visa □**1yr / 2yrs / 3yrs**Overseas Visitor □** | **Yes** | **No** | **N/A** |
| **Emergency Contact** | **Name/Surname** | **Relationship** | **Address / Town or City** | **Yes** | **No** | **N/A** |
| **Mobile Phone** | **Home Phone** | **Email Address** | **Yes** | **No** | **N/A** |
| **Medical Information** | **Regular GP** | **Practice Name & Address** |
| By completing and signing this form you agree that as a Casual Patient you are required to pay your account at the time of your consultation.  | **Yes** | **No** | **N/A** |
| I have provided one of the following as proof of identity (circle): ***Drivers Licence / Birth Certificate / Passport / Work Visa*** | **Yes** | **No** | **N/A** |

**Signature**: **Date:**