**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**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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:**