Twizel Medical Centre Casual Patient Information

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

				OFFICE USE ONLY Yes	No	N/A
Title (circle)	**Mr Mrs Miss Ms Dr**		**Assigned Sex (Circle):** **Male Female** **Preferred Gender:** _____ **Preferred Pronoun:** _____			
Legal Name	**First Name:** **Preferred First Name:**	**Middle Name(s):**	**Surname:**			
Birth Details	**Day / Month / Year**	**Place of Birth**	**Country of Birth**			

Which ethnic group do you belong to? Mark the space or spaces which apply to you				OFFICE USE ONLY Yes	No	N/A
◯	New Zealand European	◯	Māori			
◯	Samoan	◯	Cook Island Māori			
◯	Tongan	◯	Niuean			
◯	Chinese	◯	Indian			
Other such as DUTCH, JAPANESE, TOKELAUAN						

				OFFICE USE ONLY Yes	No	N/A
Contact Details	**Landline / Mobile:**	**Email Address:**				
Usual Residential Address	**House (or RAPID) Number and Street Name**	**Suburb / Rural Delivery**	**Town / City and Postcode**			
Postal Address (If different from above)	**PO Box or House Number and Street Name**	**Suburb / Rural Delivery**	**Town / City and Postcode**			

Occupation	**Occupation:** **Name/Address 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	**Fulll Name**	**Relationship**	**Address & Town**	**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:**_____