Kawerau Medical Centre

Te Heke Mai o Te Hauora
The Future of Health Care

CASUAL REGISTRATION FORM

SURNAME ______________________________ FIRST NAME/S ______________________________

PREFERRED NAME _____________________ DATE OF BIRTH ________________________ TITLE __

PHONE NUMBER _____________________ MOBILE NUMBER ____________________________________

ADDRESS ____

CURRENT MEDICAL CENTER: ____

NHI NUMBER ______________________________ **(***if known)*

ETHNICITY

Which ethnic group do you belong to? Mark the space/s that apply to you

☐ NEW ZEALAND EUROPEAN
☐ MAORI
☐ SAMOAN
☐ COOK ISLAND MAORI
☐ NIUEAN
☐ TONGAN
☐ CHINESE
☐ INDIAN
☐ OTHER (Such as DUTCH, JAPANESE, CAMBODIAN etc.) PLEASE SPECIFY:

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OCCUPATION _______________________________ EMPLOYER ___________________________________

EMERGENCY CONTACT:

NAME ____ PHONE NUMBER ______________________________

RELATIONSHIP*(E.g. Parent, neighbour):________________ ADDRESS ___________________________________

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SMOKING is an important factor in health. Please tick the option below that best applies to you:

❑Never Smoked ❑Current Smoker ❑Past Smoker – 12 months + YES / NO

If you are a current smoker, would you like help to quit? YES / NO

WHERE DID YOU HEAR ABOUT US? (Please tick one)

☐ From a friend/Word of mouth
☐ Radio/Newspaper/Kawerau Echo Newsletter
☐ Social Media/Website
☐ Other