Kawerau Medical Centre

REGISTRATION FORM

SURNAME*: _____ FIRST NAMES*: _____ TITLE ____

PREFERRED NAME: _____ DATE OF BIRTH*: _____

PHONE NUMBER: _____ MOBILE NUMBER: _____

EMAIL: SURVEY:(please circle) YES NO

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT:

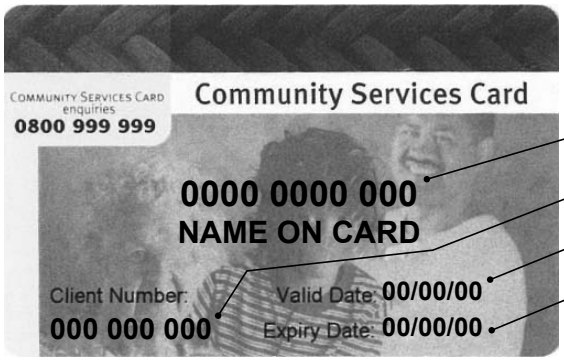
NAME*: _____ PHONE NUMBER*: _____

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

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

STATUS: ❑ Never Smoked ❑ Current Smoker ❑ Past Smoker – 12 months or more YES / NO

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



COMMUNITY SERVICES CARD (IF APPLICABLE):

CARD NUMBER*: _____

CLIENT NUMBER*: _____

VALID*: _____ / _____ / _____

EXPIRY*: _____ / _____ / _____

SUPER GOLD CARD (IF APPLICABLE):

CARD NUMBER* _____

CLIENT NUMBER*: _____

VALID*: _____ / _____ / _____

EXPIRY*: _____ / _____ / _____
