Kawerau Medical Centre

REGISTRATION FORM

SURNAME*: _____ FIRST NAMES*: _____ TITLE____

PREFERRED NAME: _____ DATE OF BIRTH*: _____

PHONE NUMBER: _____ MOBILE NUMBER: _____

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT:

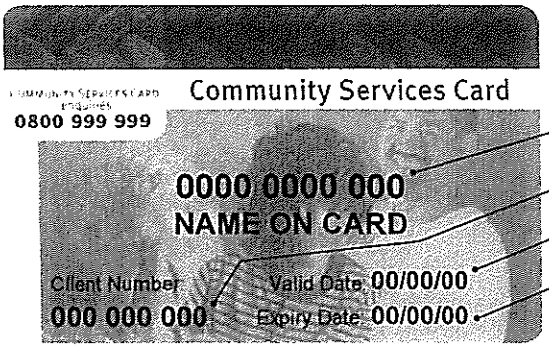
NAME*: _____ PHONE NUMBER*: _____

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



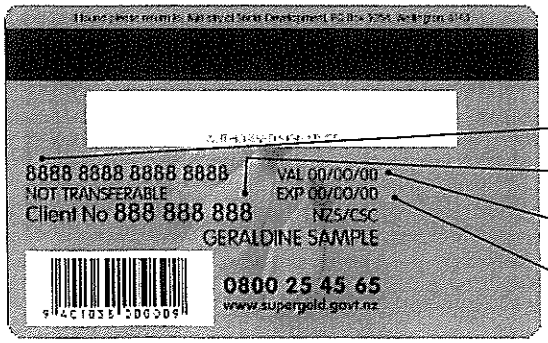
COMMUNITY SERVICES CARD (IF APPLICABLE):

CARD NUMBER*: _____

CLIENT NUMBER*: _____

VALID*: ____ / ____ / ____

EXPIRY*: ____ / ____ / ____



SUPER GOLD CARD (IF APPLICABLE):

CARD NUMBER* _____

CLIENT NUMBER*: _____

VALID*: ____ / ____ / ____

EXPIRY*: ____ / ____ / ____

Kawerau Medical Centre

26 Islington Street, Kawerau 3127
P O Box 35, Kawerau 3169
Phone: 07 323 6249 **Fax:** 07 323 6349
Email: reception@kaweraumedcentre.co.nz

Dear _____ **(Previous Medical Centre)**

The following patient /patients have transferred to this practice and it would be appreciated if their records could be forwarded to the above address.

NHI:

Name:
Date Of Birth:

Additional family members:

Their address now is:

Yours sincerely

Dr Emily Hermanson
NZMC: 40547
Kawerau Medical Centre
EDI: kaw26med

I consent to the transfer of my / our records to Dr Emily Hermanson.

Patient Name:

Signed :_____ Date: