Patient Information Form: Westgate Medical Centre

ALL FEES MUST BE PAID IN FULL AT TIME OF CONSULTATION

If you have any queries, disabilities or problems filling out this form don't hesitate to contact our staff for help.

SURNAME: _____

FIRST NAME: _____

MAIDEN NAME: _____

TITLE: _____

DATE OF BIRTH: _____

COUNTRY OF BIRTH: _____

HOME PHONE NO: _____

EMAIL: _____

ADDRESS: _____

_____

CELL PHONE NO: _____

WORK PHONE NO: _____

OCCUPATION: _____

EMPLOYERS NAME AND ADDRESS:

_____

_____

PRIVATE HEALTH INSURANCE: YES/NO

NAME OF COMPANY: _____

COMMUNITY SERVICES CARD: YES/NO

NEXT OF KIN:

NAME: _____

RELATIONSHIP: _____

PHONE NO: _____

RESIDENCY STATUS: **(Please circle)**

NZ PERMANENT RESIDENT **2 YEAR VISA**

NON NZ RESIDENT **NZ CITIZEN**

REGISTRATION:

DO YOU WISH TO BECOME A PERMANENT PATIENT AT WESTGATE MEDICAL CENTRE: YES / NO

WITH WHICH DOCTOR DO YOU WISH TO REGISTER:

_____

WHO IS YOUR PREVIOUS GP WHERE WE CAN OBTAIN YOUR MEDICAL RECORDS.

NAME: _____

ADDRESS: _____

CASUAL PATIENTS ONLY - WHO IS YOUR USUAL GP ?

NAME: _____

ADDRESS: _____

Copies of your consultation notes will be forwarded to your GP unless the doctor is specifically requested not to do so.

ETHNICITY:

Please define as clearly as possible. The Ministry of Health requires us to collect this information for studies of population data.

Please tick box:

NZ European		Maori		Samoan		Cook Island Maori		Tongan		Niuean		Chinese		Indian	
Other		Please Specify:											

NAMES OF CHILDREN WHO YOU WISH TO HAVE SEEN AT WMC

SURNAME	FIRST NAME	GENDER	DATE of BIRTH	ETHNICITY	MEDICINE ALLERGIES	REGISTER WITH WMC
		M / F				YES / NO
		M / F				YES / NO
		M / F				YES / NO
		M / F				YES / NO

PATIENTS WILL NEED TO PAY ANY FEES DUE AT THE TIME OF SERVICE. In special circumstances registered patients may apply for an account which must be settled on receipt of an invoice (special conditions apply). I understand that if my account is not paid within 14 days, an administration fee of $5 will be added to my account. I also understand that if my account is outstanding after 60 days with no arrangements made for payment, that I shall be responsible for payment of all costs and expenses incurred by you instructing a solicitor and/or debt collection agency to recover any overdue payment. I consent to receiving text messages on my mobile phone and e-mail.

_____ (SIGNATURE) _____ (DATE)

How did you hear about Westgate Medical Centre? (Please circle)
Advertisement / Phone book / Work / Friend or family / Pharmacy / Phone helpline / Dr referral / Saw a sign

Do you consent to your name being included in various screening programs that are relative to your health. You will then receive recall letters to come in for various screening tests when due, eg: cholesterol, sugar, cervical smears, mammograms etc. Your privacy will be maintained.

☐ I consent ☐ I do not consent

Form dated 13 Dec 2011