REGISTRATION FORM:

CASUAL PATIENT

LEESTON MEDICAL CENTRE

FIRST NAME: _____ **FAMILY NAME:** _____

GENDER: _____ **DATE OF BIRTH:** _____

ETHNICITY: _____ **PHONE:** _____

EMAIL: _____@_____

RESIDENTIAL STATUS (Please tick):

New Zealand- ☐ Eligible Non-New Zealand- ☐ Non-New Zealand- ☐

ADDRESS: _____

Suburb/Town: _____City: _____ Postcode: _____

EMERGENCY CONTACT NAME: _____**PHONE**: _____

EMPLOYER / COMPANY: _____

CURRENT MEDICAL PRACTICE / DOCTOR: _____

IDENTIFICATION DOCUMENT (Original to be presented to reception) Please tick:

Driver's Licence ☐ Passport ☐ Birth Certificate ☐ Other: _____

MEDICAL HISTORY:

Do you suffer from any of the following (Please tick):

High Blood Pressure ☐ Heart Disease ☐ Asthma ☐

Diabetes ☐ Cancer ☐ Stroke ☐

MEDICATIONS (Please list all currently being taken): _____

_____

Do you have any **allergies, sensitivities,** or **drug reactions**? YES / NO

CHILDREN - Are your **IMMUNISATIONS** up to date? YES / NO

ADULTS - Have you had a **Tetanus Immunisation** in the **last 10** years? YES / NO

FEMALES - Have you had a **Cervical Smear** in the **last 3** years? YES / NO

SMOKING STATUS- Are you currently smoking? YES / NO

If yes, how many per day? _____

ALCOHOL STATUS- Do not drink alcohol. YES / NO

If yes, how many glasses do you drink in an average week? _____.

I, hereby confirm that the details provided are true to the best of my knowledge and that the payment in full, is required at the consultation time.

Signature of Patient/Guardian: _____ Date: _____