



First Name: _____ Gender: _____
Surname: _____
AFFIX PATIENT LABEL HERE
Date of Birth: _____ NHI#: _____
Ward/Clinic: _____ Consultant: _____

Date: _____

Updated by: Signature: _____

General

Patient Registration

IS THIS AN ACCIDENT /INJURY: YES OR NO (Please circle one)

Preferred title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed
Surname: _____ Given Names: _____ Permanent Home/ Street Address: _____ Telephone numbers: Home: _____ Work: _____ Cell phone: _____		Former Surname/Maiden Name/ Also known as: _____ Date of Birth: _____ Age: _____ Which ethnic group do you belong to? <i>Mark the box(es) which apply to you. For information on why ethnicity information is collected please see over page –You can select a maximum of 3.</i> <input type="checkbox"/> NZ European <input type="checkbox"/> Niuean <input type="checkbox"/> Māori <input type="checkbox"/> Chinese <input type="checkbox"/> Samoan <input type="checkbox"/> Korean <input type="checkbox"/> Cook Island Maori <input type="checkbox"/> Tongan <input type="checkbox"/> Indian If your ethnic group is not in the list above please state: _____	
Next of Kin: <i>(For an explanation please see over page)</i> Name: _____ Address: _____ Telephone number: _____ Relationship: _____		Smoking Status (please tick appropriate box): <input type="checkbox"/> Never Smoked <input type="checkbox"/> Current Smoker (within 4 weeks) <input type="checkbox"/> Ex Smoker	
Alternative/Emergency contact: <i>(For an explanation please see over page)</i> Name: _____ Telephone number: _____ Relationship: _____		Local Address at time of Admission: <i>(If different from permanent address)</i> _____ Telephone number: _____	
Family Doctor or GP: (Full name, address, including telephone number where possible) Name: _____ Name of Practice: _____		When and where were you last in hospital? <i>(This is so that we can locate any other medical notes you may have)</i> Inpatient/Outpatient? _____ What hospital? _____ When? _____ Surname at the time? _____	
Residency Status: <i>(Hospital charges may apply to non-NZ residents. See over page)</i> Country of Birth _____ Are you a permanent NZ resident <input type="checkbox"/> Yes <input type="checkbox"/> No Occupation: _____ Religion: (optional please see over page)		What language do you speak? _____ Do you require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No This form was filled in by: <input type="checkbox"/> Myself <input type="checkbox"/> Other Print Name: _____ Relationship: _____ Signature: _____ Date: _____	

Please turn over the page for more information on the questions that we are asking you to complete in this form. This information is critical for your care and in some cases may be required by the Government.

First Name: _____	Gender: _____
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1: Why do you need my ethnicity information?

Ethnicity data are part of a set of routinely collected administrative data used by health sector planners, funders and providers to design and deliver better policies, services and programmes. Better information will help improve every New Zealander's health by providing a sound basis for decision-making.

In New Zealand, ethnic identity is recognised as an important dimension of health inequalities. The impact of those factors is particularly evident amongst Māori and Pacific peoples, whose health status is lower on average than that of other New Zealanders.

Ethnicity is self-perceived, so the person concerned should identify their ethnic affiliation wherever feasible. A person can belong to more than one ethnic group and the ethnicities with which a person identifies can change over time.

2: Religion

This information is made available to our chaplains. Complete this box if you are affiliated to a particular religious or cultural group. This will enable Waitemata District Health Board to provide appropriate support if (i) there are any religious considerations that you would like us to know about; (ii) if you would like or need religious support. Our Chaplains provide non-denominational support, friendship and counselling, as well as referral to other religious groups.

3: Next of Kin and Alternative/ Emergency Contacts

Waitemata District Health Board needs the name(s), addresses and telephone numbers of your preferred contacts. These contacts do not have to be a family member, but it is necessary that the person(s) that you list here knows that you have nominated them. This information allows the hospital to call them to support you, and/ or to accept interim decision-making in an emergency, or allow us to divert enquiries about your health to that person.

4: Charging Policies:

Only people meeting the eligibility criteria defined in the Government's 2003 Eligibility Direction policy are entitled to publicly-funded care in New Zealand. There is a detailed guide at <http://www.moh.govt.nz/eligibility> but essentially eligible people are New Zealand citizens and permanent residents; work permit holders here for two years or more; specific categories of students; refugee and asylum seekers; and Australian and UK citizens who become acutely unwell.

All patients will be asked to provide proof of eligibility before treatment or after urgent treatment - either a photocopy of:

- your passport (both the first page and the page showing any relevant visas or permits);
- a NZ birth certificate;
- a NZ Citizenship certificate; or
- a letter from Immigration of acceptance of refugee status.

No one will be refused urgent treatment, but ineligible patients will be billed for this afterwards.

In order to determine your eligibility we may disclose information to the New Zealand Immigration Service. Only the minimum information necessary to determine your eligibility (generally your name, gender and date of birth) will be disclosed, and only for the purposes of determining your eligibility.

For more information go to the MoH website <http://www.moh.govt.nz/eligibility>, or call the Eligibility Office on: 09 440 6920.

5: Patient Privacy

Waitemata District Health Board (WDHB) is required to protect your privacy and **will only use your information in order to provide you with care and treatment or for reasons directly related to the provision of your health services**. In certain circumstances WDHB may be legally required to provide some of this information to other government agencies e.g. **NZ Police, Income Support or NZ Immigration Service**.