R C N O

CONFIDENTIAL

Massey University Health & Counselling Centre

PATIENT REGISTRATION FORM

Please complete the details below and return to the Health & Counselling Centre Level 2, Student Central Building, East Precinct, Auckland campus

(Where there is a choice of answers tick (✓) those which apply to you).

PERSONAL DETAILS **Student/Staff ID Number**:………………………………

Full Surname: ……………………………………… **Other Names (i.e. Maiden Name):**…………………….…

First Name/s (in full): ………………………………… **Preferred or English Name:** ……………………….….

Address: ………..

………………………………………………………………………………………………………**Post Code:**…………………

Date of Birth: day……….month……..year…….. **Gender:** Male ☐ Female ☐ Other ☐

Home Phone:…………………………. **Mobile**: …………….…………..….. **Extn:** (Staff only) ……………..…

☐ Please tick if you **DO NOT** give permission for the Health & Counselling Centre to ring or text your mobile phone.

Email: ……………………………………………………………………….…. **NHI Number:** ……………………

Community Services Card Number: …………………………………………. **Expiry Date:** …………………….

New Zealand Citizen / Permanent Resident:

Yes ☐ No ☐ **First Arrival Date in New Zealand**:…………….. **Visa Expiry Date:** ………

Study Visa Expiry Date: ……………………………… **Work Permit Expiry Date:** …………………………………

Medical Insurance Policy/Number: ………………… **Insurance Company:** ….……… **Expiry Date:** …..............

Ethnicity: *(tick which apply)*

New Zealand European		Fijian	
Maori *(please state Iwi)*		Indian	
Samoan		South East Asian	
Cook Islands Maori		Chinese	
Tongan		Middle Eastern	
Niuean		European	
Other *(please state)*			

Emergency Contact/Next of Kin: Name:…………………….... Relationship:……….. Telephone: ……..………..

UNIVERSITY COURSE you have enrolled in:

Humanities & Social Sciences ☐ Design/Fine Arts/Music ☐ PaCE ☐
Business ☐ Engineering ☐ (English Language School)
Education ☐ Science ☐

Are you? Postgraduate ☐ Internal Student ☐
Undergraduate ☐ Extramural Student ☐
Staff ☐ Accommodation Student ☐

How did you hear about the Centre? ……………………………………………………………………………..

Consent for the collection, use & release of information

I authorise the collection, use and release of any information about me to the extent that it is needed to assess and manage my health care. I understand that this authority relates to all aspects of my health care including screening, recall activities and counselling, while under the care of the Health & Counselling Centre including external and internal agencies such as the Ministry of Health, hospitals, specialists, ACC, PHO and other medical and mental healthcare providers.

I understand that Massey University Health & Counselling Centre will at all times comply with the guidelines of the 'Privacy Act 1993 and Health Information Privacy Code 1994'.

I understand that this practice is entitled to charge a fee for the health and counselling services it provides and that I agree to pay such costs according to the policy of the practice including any additional costs associated with the collection of overdue or unpaid accounts. In the event of an ACC claim being declined I agree to pay the balance of the fee owing.

Client Signature…………………………………………………….Date……………………

P.T.O.

<u>If you would like to use the services of our Doctor at some stage whilst studying, please turn over</u>

Please complete this page if you would like to use the services of our Doctor whilst studying

Would you like to enroll as a patient here whilst you are studying at Massey University? Yes ☐ No ☐
(Note: you cannot be enrolled with more than one medical practice at a time).

If No, who is your Regular Doctor ……………………………………………………….. **Telephone**………………

INTERNATIONAL STUDENTS - **Have you seen another Doctor or Medical Centre since you have been in New Zealand?**

No ☐ Yes ☐ **If Yes, where were you treated?** ……………………………………………………..…

Personal History Please enter details of any disease you have had in the past, or have now:

DISEASE	NO / YES	DETAILS	DISEASE	NO / YES	DETAILS
Asthma			Migraine		
Diabetes			Other Disease *e.g. Hepatitis*		
Epilepsy			Cardiac Condition *e.g. murmur, hypertension*		
Psychiatric Condition *e.g. depression / anxiety*					

Additional information *e.g. Operations*: ……………………………………………………………………………………….………

Allergies Are you allergic to any medicines, tablets, injections or anything else eg. Bees?
No ☐ Yes ☐ If Yes, please enter details:

ALLERGIES	NO/YES	DETAILS/REACTION TO THE MEDICATION
Drug Allergy		
Other Allergy		

Do you have a disability? No ☐ Yes ☐ *If Yes, please provide brief details:* ………………….….….…
………………………………………...

Medication
List all medications you are taking including any supplements and medicine brought from Pharmacy.
……….…
……….

General
Do you smoke or have you EVER smoked cigarettes? **NO / YES**
If YES and you STILL SMOKE, how many cigarettes do you smoke **per day**? (Average) Nil 1-10 11-20 >20
How many **years** have you smoked? ……………………………..
Would you like to give up smoking? **NO / YES**
If you have stopped smoking, **how many years ago did you stop**? …………………………..

How many **alcoholic drinks** do you have a **week**? None 1-10 11-20 >20

Family History Has any blood relative had any of these diseases? *(Please state which relative and give details)*

DISEASE	RELATIVE	DETAILS	DISEASE	RELATIVE	DETAILS
Asthma			Epilepsy		
Diabetes			Psychiatric Condition		
High Blood Pressure			Blood Clots		
Heart Attack			Migraine		
Stroke			Other		
Cancer					

Write any further details here ……………………………………………………………………………………………