

2020

Massey University Health & Counselling Centre : Manawatu

PATIENT REGISTRATION FORM

If you are a **NZ student who wishes to stay enrolled with your own GP** and use Massey Student Health as a casual patient, or you are an **International Student**, please complete the details below & return to Student Health Reception, Level 1, Registry Building. **Note: This form is only valid for the current academic year.**
(Where there is a choice of answers tick (✓) those which apply to you).

PERSONAL DETAILS

Student ID Number:

Full Surname: First Name (in full):

Other Names (ie Maiden Name):..... Preferred or English Name:

Address:

Date of Birth (dd/mm/yyyy): Gender: Male Female Gender Diverse

Home Phone: Mobile:

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

Email: NHI Number (if known):

Community Services Card: Yes No Card Number:.....Expiry date:

New Zealand Citizen / Permanent Resident: Yes No

If No: First arrival date in New Zealand:..... Visa Expiry Date:

Study Visa Expiry Date:..... Work Permit Expiry Date:.....

Medical Insurance Company: Expiry date:

Ethnicity: (tick which apply)

New Zealand European		Maori		Samoan	
Fijian		Cook Island Maori		Tongan	
Nuiean		Indian		South East Asian	
Chinese		Middle Eastern		European	
Other (please state)					

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

Telephone:

Consent for the collection, use & release of information:

- I consent to Massey Student Health & Counselling Manawatu requesting a copy of my medical history from my current GP to ensure ongoing continuity of care.
 - PMS Front Page (including regular medications & dose); Medicine allergies; Immunisation history

I authorise the collection, use and release of any information about me to the extent that 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.

Signature: Date:.....

Please turn over & complete Medical History

MEDICAL HISTORY

REGULAR DOCTOR:

NZ Students: Who is your regular doctor (*GP Name, Practice Name, Town/City*):
 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 tick & enter details of any disease you have had in the past, or have now:

DISEASE	YES	DETAILS	DISEASE	YES	DETAILS
Asthma			Migraine		
Diabetes			Other disease eg Hepatitis		
Epilepsy			Cardiac Condition eg murmur, hypertension		
Psychiatric Condition eg depression/anxiety					

Additional information eg 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 MEDICATION
Drug Allergy		
Other Allergy		

Do you have a disability? No Yes If Yes, please provide brief details?

Medication

List all the medications you are taking including any supplements and medicine bought from a Pharmacy

Smoking Status: No Never Smoked Ex-Smoker Date quit:
 Current Smoker Approx. smoked per day

If Current Smoker:

The best advice we can give you for your health and well-being is to quit smoking. Here at the Massey University Health Centre we can help you on your journey to wellness. Please tick if you would like to be contacted for support to quit smoking.

Yes, to be contacted

No, no contact at this time (you may be asked again in the future)

Alcohol: How many alcoholic drinks do you have in a week: None 1-10 11-20 >20

Family History: Has any blood relative had any of these diseases? (*Please state relative eg father 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