

# Client Registration Form



Client No: \_\_\_\_\_ NHI No: \_\_\_\_\_

Please fill out all sections of this form and give it to the receptionist. If you have any questions the receptionist will be happy to help you.

Have you been to Family Planning before? Yes  No  If yes, which clinic \_\_\_\_\_

Do you hold a Community Services Card? Yes  No  If yes, please fill in details below

CSC Card No: \_\_\_\_\_ Expiry date: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name/s \_\_\_\_\_

Preferred Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender: Male  Female  Gender Identity \_\_\_\_\_

Street Name and Number: \_\_\_\_\_

Suburb \_\_\_\_\_ City/Town \_\_\_\_\_ Postcode \_\_\_\_\_

Email address: \_\_\_\_\_ Day Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Can we contact you by? Mail Yes  No  Email  Mobile

Which ethnic group do you belong to? You can select more than one.

Māori  Niuean  Tongan  Cook Island Māori  Samoan  Indian  Chinese  NZ European

Other (please state) \_\_\_\_\_

Do you need an interpreter? Yes  No  Language \_\_\_\_\_

Do you need any special help (e.g. deaf interpreter, mobility, sight)? Please fill in \_\_\_\_\_

Your GP Name \_\_\_\_\_ Medical Centre Name \_\_\_\_\_

**Eligibility Criteria:**

Country of Birth: \_\_\_\_\_ NZ Citizen: Yes  No

NZ Resident: Yes  No  Passport sighted (*office use only*) \_\_\_\_\_

Student and / or other overseas visitor eligible for health funding Yes  No

Visa sighted for work permits and / or visa (*office use only*) \_\_\_\_\_

**Declaration:**

All this information is correct. Yes  No

I have seen a copy of the Health and Disability Code of Rights Yes  No

Full Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Family Planning services are only partly funded by the NZ Government. Would you like to find out how you can support our work? Yes  No

*Office Use Only:*

Proof of ID sighted Yes  No  Staff Member Name \_\_\_\_\_ Signature \_\_\_\_\_