

# Client Registration Form



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

NHI \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

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

### What are your pronouns?

She/Her  He/Him  They/Them  Something else  \_\_\_\_\_

### How do you describe your gender?

Female  Male  Non-Binary  Another Gender  \_\_\_\_\_ Prefer not to say

### What was your sex recorded at birth?

Female  Male  Another term  \_\_\_\_\_ Prefer not to say

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

NZ European  Māori  Samoan  Cook Island Māori  Tongan  Niuean   
Chinese  Indian

Other (Please state): \_\_\_\_\_ Country of Birth \_\_\_\_\_

Iwi affiliation: \_\_\_\_\_

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

Do you need assistance at your appointment e.g. a deaf interpreter? Yes  \_\_\_\_\_ No

How can we contact you? Only give your email address if you want to be contacted by email. We may also send mail to the address you give us.

Email  Phone  Text  (Only tick those that apply)

Email address \_\_\_\_\_

Mobile phone number \_\_\_\_\_ Other phone number \_\_\_\_\_

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

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

### If you are not a NZ Resident or Citizen you may not be eligible for public funded healthcare.

NZ Citizen Yes  No  NZ Resident Yes  No

We do not send information to your doctor/medical centre unless you consent. At each appointment, we will ask if you want to share information with your doctor/medical centre.

Medical centre \_\_\_\_\_ Doctor's name \_\_\_\_\_

I don't have a medical centre

**Data Collection:** This information is collected to create a digital medical record to help us provide you with the best care. Your information is protected by the Health Information Privacy Code 2020.

**Declaration:** I confirm this information is correct and agree to Family Planning creating a digital medical record. I have seen a copy of the Health and Disability Code of Rights. I understand that whichever Family Planning clinic I attend my medical record is accessible.

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

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

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