PATIENT CASUAL FORM

ALBAHADLY MEDICAL LTD
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Fields with * are compulsory	***PLEASE COMPLETE ONE FORM PER PERSON***	**NHI** *(Office use only)*

Name	Title	* Given name	* Other given name(s)	* Family name
Other name(s) (e.g. maiden name) Please tick the name you prefer to be known as				
Birth details		* Day / Month / Year of birth	* Place of birth	* Country of birth
Gender		☐ Male ☐ Female ☐ Gender diverse (please state)		Occupation

Usual residential address	* House (or RAPID) number and street name	* Suburb/rural location	* Town / city and postcode
Postal address (if different from above)	House number and street name or PO Box number	Suburb/rural delivery	Town / city and postcode

Contact Details	Mobile Phone	Home Phone	Email Address	
Emergency Contact	Name		Relationship	Mobile (or other) Phone
Employer Details	Employers Name		Workplace Address & Phone	
Ethnicity Details	○ **Māori** ○ **NZ European** ○ **Cook Island Māori** ○ **Samoan**	○ **Tongan** ○ **Niuean** ○ **Chinese** ○ **Indian**	**Other** (please specify below)	

Registered with another GP practice	*I would like my registered GP to get a copy of the records from this consultation*		
	☐ Yes, please send a copy of my consultation record	☐ Do not send	☐ Not applicable
	Registered GP and/or practice name	Address / location	

Signatory details	* **Signature**	* **Day / Month / Year**	☐ Self-signing	☐ Authority[1]

1. An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Your personal health information such as medical conditions, medications, lab result information will be collected and shared with ProCare, our Primary Health Organisation, to improve the quality of services and for statistical reasons and population health improvement. If you do not agree to any data sharing of this information, then let the practice know.

Non-sharing of health information	*I would like to opt-off from any data sharing of my health information with external agencies.* *I will remain as a casual non-enrolled patient*
	OFFICE USE ONLY