MANUKAU CITY MEDICAL CENTRE LTD

18 Manukau Station Road, Manukau City, Auckland
Phone: 09 2622011 Fax: 09 2622015 EDI: mcmcltds

CASUAL FORM

Title

Mr Mrs Ms Miss Dr

Surname ____________________

First Name ____________________

Preferred First Name

Other Known Names

NHI Number

Date of Birth

________ / ____________ / ________
Day Month Year

Gender

Male / Female

Residency Status

Place of birth

Suburb ____________________ City/Town ____________________ Country____________________

Physical Address:

Home Phone ____________________

Mobile Phone ____________________

Next of kin

Name: ____________________

Phone number: ____________________

Relationship: ____________________

Community Services Card

Number: ____________________

Expiry date: ____________________

Do you Smoke YES/NO **Do you agree to text messaging YES/NO**

Do you agree to receiving emails YES/NO Email Address:____________________

Which Ethnic Group do you Belong To? Tick the box or boxes that apply to you

NZ European	☐	Cook Island Maori	☐	Chinese	☐
Maori	☐	Tongan	☐	Indian	☐
Samoan	☐	Niuean	☐	Other *(please specify)*	☐ ____________

Employment Details

Company Name: ____________________ Address: ____________________

Occupation: ____________________ Phone: ____________________

Do you wish to have your notes sent to your own doctor? **Yes** ☐ **No** ☐

If **YES** please give details of your own doctor: ____________________

Signature: ____________________ Date: ____________________

I UNDERSTAND THAT IF I WISH TO BECOME AN ENROLLED PATIENT WITH THIS PRACTICE I WILL NEED TO COMPLETE AN ENROLMENT FORM AND SHOW EVIDENCE OF ELEGIBILITY. ASK RECEPTION FOR DETAILS.