AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Registration Form

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

PATIENT DETAILS

Non-NZ Residents please write **name as per passport,** supply **permanent overseas address.** Complete **insurer details on Page 2**

FAMILY NAME	**GIVEN NAME(S)**	**PREFERRED NAME**
PREVIOUS FAMILY NAME	ALSO KNOWN AS	

GENDER: ☐ Male ☐ Female ☐ Gender diverse
OR ☐ Please specify _____

Title *(e.g. Mr/Mrs)* _____

OCCUPATION

Date of Birth	Country of Birth	NZ Resident? ☐ Yes / ☐ No *(tick below)* ☐ Visitor ☐ Student ☐ Work Visa	Date of Arrival in New Zealand

ADDRESS
Permanent:

Temporary:
(NZ Address)

PHONE NUMBER
Home: Work:
Cell Phone:
Temporary Phone Number:

PATIENT E-MAIL ADDRESS FOR RECEIPT OF CLINICAL CORRESPONDENCE (PLEASE PRINT CLEARLY)
Please provide your e-mail address ONLY if you are happy for ADHB to send your clinical correspondence via e-mail instead of NZ Post. We may also invite you to give us feedback about your care. Advise ADHB in writing immediately if your contact information changes. Note: If you provide your email address, you will receive a separate email asking you to validate this email address.

LEAD SUPPORT PERSON: Name:
Address:
Relationship:
Home Phone: Work Phone:
Cell Phone:

ALTERNATIVE CONTACT: Name:
Address:
Relationship:
Home Phone: Work Phone:
Cell Phone:

FAMILY DOCTOR Name: Practice:

ETHNIC GROUP: Tick as many boxes as you need to show which ethnic groups you belong to:

☐ NZ European	☐ Maori	☐ Tongan	☐ Chinese	☐ Other (such as Dutch, Japanese, Tokelauan)
☐ Cook Island Maori	☐ Samoan	☐ Niuean	☐ Indian	**Please state:**

Do you require an interpreter? ☐ Yes ☐ No If yes, please specify language:

Is this visit injury related? ☐ Yes ☐ No **If yes, complete Page 2 (this is mandatory if you want us to lodge your ACC Claim)**

CHAPLAINCY: Would you like a chaplain to visit you? If yes, state Religion: _____

Have you been in hospital before? Hospitals and years: _____

PAYMENT FOR TREATMENT

If you are not eligible for publicly funded healthcare you will be charged for all services provided, with the exception of compulsory care provided under the Mental Health (compulsory Assessment and Treatment) Act 1992 which is publicly funded for all. ADHB Finance staff will advise if you are ineligible and must pay for services provided once they have reviewed the information you provide to us. We may need to disclose your information to NZ Immigration Services, who in turn will provide ADHB with the information they hold as to your residency status. By signing this form you acknowledge and consent to this disclosure by us and by NZIS.

GENERAL PRIVACY STATEMENT

We collect your health information to provide you with appropriate care, to plan for and fund health services, to carry out research and teaching and to monitor quality. To further health research and education you may be invited to participate in research projects and education of healthcare professionals. We share your information with other health care providers and agencies to assist in the provision of your care. We treat your information as confidential and ensure that it is kept secure and only accessed by authorised persons. You have a right to request access to your records and to request correction of the information. Information may be supplied to family, support people or other agencies if you give us your permission or disclosure is authorised by law.

I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENTS OR EXPLANATION BY AN INTERPRETER. I DECLARE THAT ALL THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT.

Name _____ Signature _____ Date _____

If next of kin or guardian, state relationship to patient _____

REGISTRATION FORM

CR0001

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Registration Form

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

REGISTRATION FORM

ACC ACCIDENT AND EMPLOYMENT DETAILS (COMPLETE ALL RELEVANT DETAILS & SIGN THIS FORM)

Date of accident: _____ **Time of accident:** _____ am ☐ pm ☐

Accident scene? Home ☐ School ☐ Sports area ☐ Farm/Orchard ☐ Industrial/construction area ☐

Medical Area ☐ Recreational area/Public building ☐ Non-recreational/Commercial area ☐

Highway/Street/Road ☐ Other Transport Area ☐ Other _____

Accident Location: (e.g. Auckland, Taupo) _____

Did the accident occur in New Zealand? Yes ☐ No ☐

What were you doing? Paid work ☐ Unpaid work ☐ Education ☐ Sports/Exercise ☐ Play/Leisure ☐

Other Specified activity ☐ Being taken care of ☐ Travelling ☐

Other _____

Did the accident involve a moving vehicle on a public road, driveway, beach? Yes ☐ No ☐

If sporting injury, name the sport _____

What happened to you? Motor vehicle – driver ☐ Motor vehicle – passenger ☐ On bicycle ☐

Motorcycle – driver ☐ Motorcycle – passenger ☐ Pedestrian (walking) ☐ Other transport-related ☐

Burn ☐ Aminal ☐ Low fall (<1m) ☐ High fall (>1m) ☐ Drown ☐ Other threat to breathing ☐

Poison ☐ Cut or pierce ☐ Collision ☐ Other _____

How was the injury caused? _____

Occupation? _____

I am in paid employment ☐ I own / part own the company in which I work ☐

I am self-employed ☐ I am not in paid employment ☐

What type of work do you do? Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very heavy ☐

Did the accident occur at work? Yes ☐ No ☐

Name of business: _____

Address of business: _____

PATIENT AUTHORISATION AND DECLARATION

To assess cover and/or entitlements, ACC may need to collect medical and other records about you from a third party. For more details see ACC's privacy notice at www.acc.co.nz/privacy.

I authorise:

- ACC to collect medical and other records which are or may be relevant to my claim
- The treatment provider to lodge this claim for me.

I declare that the information I have given in this form is true and correct.

Name: _____ Signature: _____
(Patient / Guardian / Representative)

Relationship: _____ Date: _____

INSURER DETAILS (TO BE COMPLETED BY ALL NON-NZ RESIDENTS)

Name of Insurance: _____ Country: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

CR0001