## Please complete this form for our records.

*All your personal information will be treated as private and confidential*

| First Names: | Last name: |
|---|---|
| Mr / Mast / Mrs / Miss / Ms /_____ | Other names: |
| Birthdate: | Ethnicity: |
| Address: | |
| Home Phone: | Work Phone: |
| Mobile: | Fax: |
| Email: | |
| Occupation: | |
| Employer Name and Address: | |
| Medical Insurance | |
| Community Services Card: Expires / / | |
| High User Card: Expires / / | |
| How did you find us :<br>Patient / Phone Book / Advert / Leaflet / Webpage / Street sign / Doctor..... | |

*Thank you*

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**If you would like to enrol as a regular patient with us...**

This is my preferred General Practice. I understand for funding purposes, I will be removed from the roll of the previous practice(s).

I understand that the above and other relevant information to secure funding and assist in your care may be sent securely and confidentially to this practice's Primary Health Organisation and the Ministry of Health.

Signed: _____ Date / /