Sexual Wellbeing Aotearoa

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.

Last Name

First Name/s

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

NHI

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

Iwi affiliation:

- ☐ Samoan
- ☐ Cook Island Māori
- ☐ Tongan
- ☐ Niuean
- ☐ Chinese
- ☐ Indian
- ☐ Other (Please state):

Country of Birth:

Residency status:

- ☐ New Zealand
- ☐ Non-New Zealand
- ☐ Eligible Non-New Zealand

Do you need an interpreter?

☐ Yes ☐ No

Language

Do you need assistance at your appointment?

☐ Yes _____

☐ No

We prefer to contact you by text. We will email and call when needed.

☐ Email

☐ Tick if you **do not** want to get texts from us.

Mobile phone number

Other phone number

Street Name and Number

Suburb

City/Town

Postcode

If you have given details for someone else **OR** you want someone to make/ change appointments for you **OR** someone else to be able to discuss your care, **ask about the Third Party Consent Form**.

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

Eligibility: I understand that different fees apply based on my NZ Citizenship or Immigration status.

I will provide proof of my eligibility if asked which may include my passport and/or visa.

Data Collection: Your information is collected/held securely in accordance with the Privacy Act 2020. It may be accessed by authorised clinical staff for your care or viewed by auditors for quality assurance/regulatory/financial purposes. We take all reasonable steps to protect your privacy.

Research: Your health information may be used for health research, but only research approved by an Ethics Committee. It will not be used/published in a way that can identify you. Except as above, details about your health or the services you received will remain confidential within Sexual Wellbeing unless you give specific consent for this information to be communicated.

Declaration: I confirm this information is correct and agree to Sexual Wellbeing creating a digital medical record. I have seen a copy of the Health and Disability Code of Rights.

I understand that whichever Sexual Wellbeing clinic I attend my medical record is accessible.

Full Name

_____

Signature

_____

Date ____ / ____ / ____