Sexual Wellbeing Aotearoa

Client Registration Form

NHI _____

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 ☐

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

Country of Birth: _____ Iwi affiliation: _____

Residency status: New Zealand ☐ Non-New Zealand ☐ Eligible Non-New Zealand ☐

Do you need an interpreter? Yes ☐ Language _____ No ☐

Do you need assistance at your appointment? Yes ☐ _____ No ☐

We prefer to contact you by text. We will email and call when needed.
Email _____ . If you **do not** want to get texts from us tick here ☐

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 ____ / ____ / ___

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