



DATE: \_\_\_\_\_

NHI: \_\_\_\_\_  
(Office use only)

**PERSONAL DETAILS:**

FIRST NAMES: \_\_\_\_\_

FAMILY NAME: \_\_\_\_\_

GENDER: Male / Female

DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cellphone: \_\_\_\_\_

EMAIL: \_\_\_\_\_

PLACE OF BIRTH: Town: \_\_\_\_\_ Country: \_\_\_\_\_

USUAL MEDICAL CENTRE: \_\_\_\_\_

**WHICH ETHNIC GROUP DO YOU BELONG TO? (YOU MAY SELECT UP TO THREE ETHNICITIES):**

NZ European/Pakeha 11 <input type="checkbox"/>	Tokelauan 35 <input type="checkbox"/>	Not Stated 99 <input type="checkbox"/>
Maori (please state iwi) 21 <input type="checkbox"/>	African 53 <input type="checkbox"/>	Declined 98 <input type="checkbox"/>
Samoan 31 <input type="checkbox"/>	Other Pacific 37 <input type="checkbox"/>	Latin American/Hispanic 52 <input type="checkbox"/>
Cook Island Maori 32 <input type="checkbox"/>	Middle Eastern 51 <input type="checkbox"/>	Fijian 36 <input type="checkbox"/>
Tongan 33 <input type="checkbox"/>	South East Asian 41 <input type="checkbox"/>	Other European 12 <input type="checkbox"/>
Niuean 34 <input type="checkbox"/>	Other Asian 44 <input type="checkbox"/>	
Chinese 42 <input type="checkbox"/>		
Indian 43 <input type="checkbox"/>		
Other (please state) 54 <input type="checkbox"/> _____		

**NEXT OF KIN / EMERGENCY CONTACT DETAILS:**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE: \_\_\_\_\_ CELLPHONE: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

**EMPLOYER / OCCUPATION: (include eg. Beneficiary, Student, Baby etc):**

EMPLOYER / COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

Or Retired / Unemployed / Beneficiary / Student (PLEASE CIRCLE)

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_