THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

HEALTH AND COUNSELLING SERVICE

International Patient Registration Form

University Health and Counselling Service
Level 3, 2 Alfred Street / Private Bag 92019
Auckland, New Zealand
Telephone 64 9 373 7599 ext 87681
Facsimile 64 9 373 7501
EDI: aukunihc
www.auckland.ac.nz/healthandcounselling
Email: uhsinfo@auckland.ac.nz

Student ID:				Date of Birth:	
Family name:					
First name:				Gender:	☐ Male ☐ Female ☐ Gender diverse (please state):
Preferred name:					
NZ Physical Address	Street:				
	Suburb:				
	City:		Post Code:		Year of study:
Phone:	Home phone:				
	Cell phone:				
	Do you agree to receive unencrypted text messages? ☐ YES ☐ NO				

Nationality/Ethnicity: Please select all that apply

☐ African	☐ Chinese	☐ Middle Eastern	☐ Southeast Asian
☐ European (please specify)	☐ Pacific Island (please specify)	☐ Indian	☐ Other (please define below)

University email address:		Other email address:		Do you agree to receive unencrypted medical information via email? ☐ YES ☐ NO

Insurance provider: ☐ StudentSafe ☐ Other (please specify)

EMERGENCY CONTACT IN NEW ZEALAND: THIS INFORMATION IS KEPT STRICTLY CONFIDENTIAL

Full name:			
Address:			
Home phone:		Mobile phone:	
How do they know you?			

NATIONAL HEALTH INDEX (NHI) IS REQUIRED FOR ALL PEOPLE SEEKING MEDICAL CARE IN NZ.
PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP US OBTAIN YOUR NHI

Passport details:	Full name on passport:		Have you ever seen a doctor or been to the hospital in New Zealand:	
	Date of arrival - stamp date:		☐ YES (Please provide more information below)	☐ NO
	Type of Visa:		Provide details of doctor/ hospital:	Date you were seen:
	Visa expiry date:			

Date you were seen:
Declaration:
I hereby declare that:
1. To the best of my knowledge all the statements in this form are correct.
2. That I have the required insurance.
3. Any treatments not covered by my insurance will be paid by me on the date seen.
4. I agree to inform the practice of any changes in my health insurance status or enrolment at the University.

Signature: _____ Date signed: _____ / _____ / _____

Confidential medical information form

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Family name:	**First name:**	**Student ID:**
Previous GP name and address:		**Preferred name:**

1. Do you have or have you had any of the following health problems? If yes, please tick √

Allergy (non-drug) Please specify:		Asthma		Epilepsy		Migraine	
Anxiety/depression/mental health problem		Diabetes		Heart disease		Bowel problems	
High blood pressure		Kidney disease		Hepatitis/liver disease		Disability	
Other, please specify:							

2. Have you been in hospital or had surgery? If yes, please supply details:

Date	The type of illness/injury/operation undergone

3. Please provide details of any medication you are currently taking (including medication purchased over the counter) :

4. Do you have any allergies (drug and/or other)? No □ Yes □ **Please provide details:**

5. Are there any significant health problems in your family? (e.g. heart disease, diabetes, blood clots, stroke, Tuberculosis, mental health problems) If yes, please supply details:

Health problem	Relationship of person to you	Age they were diagnosed

6. Do you smoke?

Yes □ No □	**If Yes,** How many cigarettes per day_____
Would you like help to quit? Yes □ No □	

7. Do you drink alcohol?

Yes □ No □
If Yes, What kind of alcohol? _____ How many drinks do you in have in a sitting? _____

8. Immunisations:

Were you immunised as a child?	Yes □ No□ Unsure □
Date of last tetanus booster	Date_____
Have you completed the Hepatitis B vaccination schedule?	Yes □ No□ Unsure □

9. List any further vaccinations since childhood e.g. meningitis, Gardasil, travel vaccines

10. Women only:

Date of last cervical smear _____	Was it normal? Yes □ No□ Unsure □
Over 45 years – Have you had a mammogram?	Yes □ No□

Signature: _____ Date:_____