Western Bay of Plenty Primary Health Organisation

CASUAL PATIENT FORM

Oceania Healthcare Centre

The Bayview

159 Waihi Road, Judea, Tauranga 3110

Circle the correct location: **ILU / CARE**

Please select Nurse Practitioner:

- **Megan Brebner - NCNZ#: 120773** ☐
- **Louise Fowler - NCNZ#: 121988** ☐

EDI: v2nh4vrx - Email: primarycare@oceaniahealthcare.co.nz- Ph: 0800 360 524

NHI:	**Birth Certificate:**	**Passport:**

Name (Title)	Given Name	Other Given Name(s)	Family Name
Other Name(s) (eg. maiden name) Please tick the name you prefer to be known as			
Birth Details	Day / Month / Year of Birth	Place of Birth	Country of birth
Gender	☐ Male ☐ Female ☐ Gender diverse (please state)		Occupation

Usual Residential Address	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

Patient Contact Details	Mobile Phone	Home Phone	Email Address
Emergency Contact or EPOA	Name / email	Relationship	Mobile (or other) Phone

Transfer of Records	*In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register, as I am only able to be enrolled at one practice at a time in New Zealand.*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Address / Location	

Ethnicity Details
Which ethnic group(s) do you belong to?
Tick the space or spaces which apply to you

- ◯ New Zealand European
- ◯ Maori
- ◯ Samoan
- ◯ Cook Island Maori
- ◯ Tongan
- ◯ Niuean
- ◯ Chinese
- ◯ Indian
- ◯ Other (such as Dutch, Japanese, Tokelauan). Please state

Community Services Card	☐ Yes	☐ No
Day / Month / Year of Expiry	Card Number	
High User Health Card	☐ Yes	☐ No
Day / Month / Year of Expiry	Card Number	

Practice Specific Field

Patient Medical Information

Blood Pressure	Weight	Height	Preferred Pharmacy	
			Name:	Address:

Current Medical Conditions	
Current Medications * Please provide current prescription or a printout from your pharmacy listing your current medications	
Any allergies?	
Any medical alerts?	
Family history of the following diseases:	☐ cardiovascular disease ☐ vascular disease ☐ Diabetes ☐ None ☐ Unknown
Previous Surgeries: *Please list any previous surgeries and the approximate year each was performed*	
Previous Procedures: *(e.g.: colonoscopy, mammogram, cervical smear, etc.) . Please list any previous medical procedures and the approximate year each was performed*	
Previous Immunizations: *Please list any immunizations received and the approximate year*	

Smoking Status: (please circle)	Current Smoker	Ex-Smoker: Less than 12 months ago ☐ More than 12 months ago ☐	Never Smoked
Day / Month / Year	Signature	Name	Authority or Self Signing