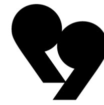
Client Registration Form



Sexual Wellbeing
Aotearoa

Please fill out all sections of this form and give to the receptionist. NHI ________________
If you have any questions the receptionist will help you.

Last Name ___________________________________ First Name _______________________________

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: ____

Do you need an interpreter? Yes ☐ Language _____________________________________ No ☐
Do you need assistance at your appointment e.g. a deaf interpreter? Yes ☐ _____________ No ☐

How can we contact you? Email is the way we prefer to contact you. We may also send mail to the address you give us.

Email ☐ Phone ☐ Text ☐ (Only tick those that apply)

Email address ____

Mobile phone number ________________________ Other phone number ________________________

Street Name and Number ____

Suburb ____________________ City/Town ________________________ Postcode _______________

If you are not a NZ Resident or Citizen you may not be eligible for public funded healthcare.

NZ Citizen Yes ☐ No ☐ NZ Resident Yes ☐ No ☐

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 _______________________

I don't have a medical centre ☐

Data Collection: Your personal information is collected and held securely in accordance with the Privacy Act 2020. It may be accessed by authorised clinical staff for your care and viewed by approved auditors for quality assurance or regulatory purposes. We take all reasonable steps to protect your privacy.
Declaration: I confirm this information is correct and agree to Sexual Wellbeing Aotearoa creating a digital medical record. I have seen a copy of the Health and Disability Code of Rights. I understand that whichever Sexual Wellbeing Aotearoa clinic I attend my medical record is accessible.

Full Name ____

Signature ____ Date _____ /_____ /_____

Sept25