



# VISITOR FORM

Centre Shop 7a, 93 Bader Drive,  
Māngere, Auckland 2022  
Ph: 027 366 3661 or 027 566 5669

				<b>*NHI (Admin to Check)</b>	
<b>Title</b>		<b>*First Name</b>		<b>*Family Name</b>	
<b>Other Names Known By (e.g maiden name, etc)</b>				<b>*Date of Birth</b>	
<b>*Gender</b>			<b>*Ethnicity</b>		
			Day / Month / Year		
<b>Address</b>				<b>Postal Address (if different)</b>	
<b>Home Phone</b>		<b>Work Phone</b>	<b>Mobile No</b>		<b>Email</b>
<b>Usual GP</b>			<b>Practice Name</b>		
<b>Would you like notes to go to your GP? Yes <input type="checkbox"/> No <input type="checkbox"/></b>				<b>Name of Emergency Contact</b>	
				<b>Emergency Contact Phone Number</b>	

**PRIVACY ACT:** Under the PRIVACY ACT 2020, your health records are confidential and only accessible to clinicians involved in your care and our administration staff. Information is not shared with third parties—except ACC, your work-place insurer, your usual doctor, or your referring clinician—without your written consent. Please inform Wellness Hub of any changes to your personal details.

**CONSENT TO TREATMENT** I consent to treatment, with the understanding that it will be fully explained beforehand. I may decline any part of the treatment offered. My provider may consult other medical professionals or access my records to ensure quality care, and I consent to the necessary release of information in these cases.

If you agreed above to share your treatment information with your GP or any specialist services involved in your care, this information will be sent to your GP and kept confidential

<b>SIGNATURE of individual or parent/Guardian if under 16 years</b>		<b>*Date</b>	
		Day / Month / Year	



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## BASIC HEALTH HISTORY

Current Medical Conditions please tick or list any that apply	YES	NO
Diabetes		
High Blood Pressure		
Heart Disease		
Asthma / COPD		
Stroke		
Mental Health Condition		
Kidney Disease		
Cancer		
<b>Other:</b> List here		

Current Medical Conditions please tick or list any that apply	YES	NO	UNSURE
Allergies to food or medication			
Do you vape?			
Are you taking any regular medications			
Are you currently pregnant or could you be pregnant?			
Are you up to date with mammograms?			
Are you up to date with cervical / HPV screening?			
Any previous surgeries or operations?			
Are you up to date with immunisations			
Do you smoke?			
Would you like support to quit smoking?			