webPAS Patient Demographic update Form

|  |
| --- |
| *The information collected from you is required by Te Whatu Ora, Te Tai Tokerau for the purpose of providing and administering health care and services to you.* |

|  |  |
| --- | --- |
| NHI | **Please write details clearly** |
| Title |  | Date of birth: |
| Surname |  | Place of Birth: |
| First names |  |
| Residential address |  Postal Code: |
| Postal address if different to residential address) |  Postal Code: |
| Phone numbers  | Home | Work | Mobile |
| GP |  |
| GP Practice |  |
| Email address  | ***Please provide your email address ONLY if you give approval for Te Whatu Ora, Te Tai Tokerau to send your clinical correspondence via email instead of post.***  Information may be less secure when sent by email. If your email is shared by others, please be aware they can view information we send you by email.It may be some time before we are able to use email but appreciate the opportunity to record your email address while you are here. |
| **CONTACTS** | **Emergency (first) Contact** | **Second Contact** |
| Contact Name  |  |  |
| Relationship |  |  |
| Contact Phone Numbers | home | work | mobile | home | work | mobile |
| Contact Postal Address | Postal Code: | Postal Code: |
| Do you need an interpreter? | No / If Yes, what language? |

Signature of patient/representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If not signed by the patient, please state relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*