DUDLEY CREEK HEALTH

447 Papanui Road,
Strowan
CHRISTCHURCH

NEW PATIENT REGISTRATION FORM

Title: _____ **First names:** _____ **Surname:** _____

DOB: _____ **Known as:** *(if different from above)* _____

Email address: (in capital letters) _____

Home address: _____

Postal address: *(if different from above)* _____

Home Ph: _____ **Work Ph:** _____ **Mobile:** _____

GP Name & Medical Centre: _____

Occupation: _____

Next of kin name: _____ **Relationship:** _____ **Phone:** _____

Are you on <u>blood thinning medication</u> (please circle): Warfarin / Aspirin / Dabigatran / Clexane / Heparin / Other

If Other, which? _____

Do you have Medical Insurance: Yes ☐ **No** ☐ **If yes, which company?** _____

<u>ACC Patients to complete:</u>

Do you have an ACC registered claim for this accident/injury? Yes ☐ **No** ☐

Was this a workplace accident? Yes ☐ **No** ☐ **If Yes, name of employer:** _____

Employer's insurer (if known): _____

In the course of a consultation and during diagnosis and treatment, information is collected for the benefit of patients. While the confidentiality of the doctor/patient relationship is always paramount, this information is also collected in order that some of it may be shared, in appropriate circumstances, with those close relatives or others who are directly involved in your ongoing care and welfare. If you have any objection to information being shared in this way please discuss this with us. Please note some clinical documents may be used for teaching purposes.

I give permission for previous medical records to be obtained if deemed necessary by my treating Specialist.

I understand I will be liable for any costs incurred in the collection of outstanding accounts.

I agree to pay for any consultations/treatment/surgery if ACC decline to pay.

Signed: _____ **Date:** _____

Relationship to patient (*if not signed by patient*)**:** _____