HARBOUR
CANCER & WELLNESS

PATIENT REGISTRATION FORM

PATIENT INFORMATION

FIRST NAME | SURNAME

HOME ADDRESS

PHONE (M) | PHONE (H)

NHI | DOB

EMAIL | GENDER

WHO DO YOU LIVE WITH?

OCCUPATION | ARE YOU A NZ RESIDENT? YES NO

ETHNICITY | COUNTRY OF BIRTH

LANGUAGE | REQUIRE AN INTERPRETER? YES NO

ALLERGIES	ALLERGEN	REACTION

MEDICATIONS	MEDICATION	DOSE/FREQUENCY

EMERGENCY CONTACT DETAILS

FIRST NAME | SURNAME

RELATIONSHIP | PHONE

EMAIL

INSURANCE INFORMATION

Do you have health insurance? YES NO If YES please provide the following:

HEALTH INSURER | POLICY #

DATE OF RENEWAL | POLICY TYPE

REFERRER & GP INFORMATION

REFERRING PHYSICIAN

REFERRING PHYSICIAN PRACTICE

GENERAL PRACTITIONER (IF DIFFFERENT TO ABOVE)

GENERAL PRACTITIONER PRACTICE

DISCLOSURE OF MEDICAL INFORMATION

I give consent for my medical record from other sites, including District Health Board records, to be accessed or requested, and for my records from Harbour Cancer & Wellness to be shared upon request by other medical professionals and insurance companies.

Initial consultation is payable at reception either prior to or at the time of your appointment. Harbour Cancer & Wellness provides various ways in which you can pay for further consultation, if required, your treatment. This will depend on whether you have health insurance, and your policy limits and exclusions if you do. You should discuss this with your Specialist at your first consultation.

Contact:
From time to time Harbour Cancer & Wellness would like to send you updates or requests for your feedback. Do you agree to receive these emails from Harbour Cancer & Wellness in the future? You can unsubscribe at any time.

YES NO

PATIENT NAME ____________________

PATIENT SIGNATURE ____________________ **DATE** ____________________