Intus Specialist Health Care - Patient Registration Form

This form is the first step in registering as a patient with us. It captures your general and medical information. The form will take approximately 10 minutes to complete. If we haven't seen you in the 12 months prior to your appointment we may ask you to fill in this form.

Patient Details		
First Name:	Surname:	Middle Name:
Preferred Name:	Date of Birth:	
NHI Number:	Occupation:	
Ethnicity:		

Contact Details	
Mobile Number:	Home Ph:
Email:	
Physical Address:	
Postal Address (if different):	
Are you a NZ resident? ☐ Yes ☐ No	
How good are you with spoken English?	☐ Fluent ☐ Not bad - may need help with complex discussions ☐ None - need assistance always

Next of Kin	
Name:	Relationship:
Contact Number:	

GP | Insurance | Preferred Pharmacy | ACC Details		
GP Name:	GP Venue:	
Do you have a preferred pharmacy?	☐ Yes ☐ No	Name:
Do you have health insurance?	☐ Yes ☐ No	Insurance company name:
Is this an ACC claim?	☐ Yes ☐ No	ACC claim number:

General Information	
Regarding your own mouth and teeth, which apply to you?	☐ Own teeth only (with or without fillings) ☐ Loose or chipped tooth or teeth ☐ Braces or retainer ☐ Caps, crowns, or veneers ☐ Implant(s) or bridge(s) ☐ Dentures
Please indicate what aids you use?	☐ Contact lenses

	☐ Hearing aids ☐ Walking aids ☐ Any other implants Details:
Do you smoke or vape? ☐ Yes ☐ No Details:	Do you drink alcohol? ☐ Yes ☐ No Details:
Do you have any allergies? ☐ Yes ☐ No Details:	Do you have any special needs we need to know about? (disability, cultural, religious, spiritual etc) ☐ Yes ☐ No Details:
Intus may send me text reminders? ☐ Yes ☐ No	
Intus may send me email correspondence? ☐ Yes ☐ No	
Intus may leave messages with a family member or on my answ me text reminders? ☐ Yes ☐ No	
Height (cm):	Weight (kg):

Current Medications

Please list all medications you are currently taking. Also include the dose and when you take it. This includes herbal or 'natural' remedies, vitamins and other supplements.

Medication Name	Dose and Frequency

Operation History

Please provide any operations you have had in the past

Operation Name	Year

Family History

Please provide information about your family's medical history, including any significant illnesses or medical conditions that your immediate family members (parents, siblings, and children) have been diagnosed with. This information will help us better understand your genetic risk factors and provide you with the most effective healthcare recommendations

Brother/Sister	Father
Mother	Children
Father's Parents	Mother's parents
Paternal Aunts/Uncles	Maternal Aunts/Uncles

Other:

Medical Conditions

Lung, breathing, or sleeping problems?	☐ Asthma / Bronchitis ☐ Obstructive Sleep Apnoea / Snoring ☐ Shortness of breath ☐ Other lung or sleeping problems Details:
Heart or circulation problems (e.g. blood pressure, fainting)?	☐ Contact lenses ☐ Hearing aids ☐ Walking aids ☐ Any other implants Details:

Condition		Details
Cancer	☐ Yes ☐ No	
Blackouts or fainting	☐ Yes ☐ No	
Heartburn / reflux / ulcers / hiatus hernia / gastric surgery	☐ Yes ☐ No	
Blood clots or excessive bleeding	☐ Yes ☐ No	
Bleeding/easy bruising	☐ Yes ☐ No	
Headaches / Stroke / TIAs / Seizures	☐ Yes ☐ No	

Diabetes	☐ Yes ☐ No	
Infections? (e.g. Hepatitis / HIV / TB / antibiotic resistance)	☐ Yes ☐ No	
Substance dependency	☐ Yes ☐ No	
Kidney problems	☐ Yes ☐ No	
Thyroid problems	☐ Yes ☐ No	
Mental health problems	☐ Yes ☐ No	
Glaucoma	☐ Yes ☐ No	
Anaesthesia or sedation problems? (You or your close family)	☐ Yes ☐ No	
Head, neck, face, jaw, throat, or nose problems	☐ Yes ☐ No	
Other conditions or comments?	☐ Yes ☐ No	

Terms and Conditions

Consultation

I understand that the consultation may include a physical examination. If I object to this, I will inform my consultant.

I understand that at any point during my treatment it may be necessary for my care to be transferred to another clinician or hospital.

Privacy Statement

Please click here if you would like to view our Privacy Statement.

Payment

Payment is required at the conclusion of your appointment. Payment is the responsibility of the individual receiving services. If you have medical insurance cover it is your responsibility to seek prior approval from your provider and contact us with your Prior Approval number. You will still need to pay on the day of your appointment and then forward your receipt on to your insurance company for their consideration of reimbursement. You are responsible for any outstanding balance if the procedure is not fully covered by insurance or ACC

If an account becomes overdue for payment, Intus may obtain from any third-party information about your contact details or personal or commercial credit arrangements including information about credit worthiness, credit standing, credit history, or credit capacity.

Please forward all invoices promptly to your insurance company to enable them to process the claim

Please note: Your insurer may require you to pay the invoice first, then submit your receipt for reimbursement.

Debt collection procedures will be initiated if the account is not paid within the specified period. This may include additional payment or a collection fee for the benefit of and enforceable by debt collection agency under the Contract and Commercial Law Act 2017.

Declaration

I confirm that I am the person that is registered on this form, or are authorised to do so as a guardian or person of authority.

Please type full name below.