Intus Specialist Health Care

Patient Registration Form — please complete all sections in block letters.
Office use — NHI: _____

Your Details

TITLE | FIRST NAME(S) * | SURNAME *

PREFERRED NAME

MIDDLE NAME(S) | DATE OF BIRTH * (DD/MM/YYYY) | OCCUPATION | NHI (IF KNOWN)

Gender * (under 16 → also complete Guardian Details below)
☐ Male ☐ Female ☐ Other: _____

Ethnicity (select one or more)
☐ NZ European ☐ British ☐ Maori ☐ Samoan ☐ Cook Island Maori ☐ Tongan ☐ Chinese ☐ Indian ☐ Other: _____

Contact Details

EMAIL *

MOBILE * | HOME PHONE

ADDRESS LINE 1 *

ADDRESS LINE 2

SUBURB | CITY *

POST CODE *

☐ Email correspondence OK? ☐ Y ☐ N
☐ OK to send SMS reminders? ☐ Y ☐ N

ALTERNATIVE POSTAL ADDRESS (if different from above)

ALTERNATIVE BILLING ADDRESS (if different from above)

Emergency Contact

FIRST NAME *

SURNAME *

CONTACT NUMBER *

RELATIONSHIP *

General — NZ Residency & English

NZ RESIDENT?
☐ Yes ☐ No

SPOKEN ENGLISH ABILITY
☐ Fluent ☐ Not bad – may need help
☐ None – need assistance

Guardian — if patient under 16

FULL NAME

RELATIONSHIP

CONTACT NUMBER

EMAIL

Health Insurance & ACC

Have insurance? ☐ Yes ☐ No
☐ Southern Cross ☐ NIB ☐ UniMed ☐ AIA ☐ Sovereign
☐ One Path ☐ Tower ☐ Partners Life ☐ Police Plan
☐ Accuro ☐ Other: _____

POLICY NUMBER

GP & Pharmacy

GP NAME * (or clinic recently visited)

MEDICAL PRACTICE

PREFERRED PHARMACY (NAME & ADDRESS)

Medications — include supplements, vitamins & over-the-counter products

#	MEDICATION NAME	DOSE	FREQUENCY
1			
2			
3			
4			
5			
6			

General Health

HEIGHT (CM) *

WEIGHT (KG) *

Do you smoke?	☐ Yes ☐ No	If yes, how often?
Do you vape?	☐ Yes ☐ No	If yes, how often?
Do you drink alcohol?	☐ Yes ☐ No	If yes, amount & frequency
Do you suffer from any allergies?	☐ Yes ☐ No	If yes, details
Special needs? (disability, cultural, religious, spiritual etc.)	☐ Yes ☐ No	If yes, details

Medical Conditions — select Yes or No for each item

Cancer (current or past)?	☐ Yes ☐ No	Type / year / treatment
Blackouts or fainting?	☐ Yes ☐ No	
Heartburn / reflux / ulcers / hiatus hernia / gastric surgery?	☐ Yes ☐ No	
Blood clots?	☐ Yes ☐ No	
Easy bruising / prolonged bleeding?	☐ Yes ☐ No	
Headaches / Stroke / TIAs / Seizures?	☐ Yes ☐ No	
Diabetes?	☐ Yes ☐ No	When diagnosed? ☐ Insulin ☐ Tablets ☐ Diet ☐ Other
Infections (Hepatitis, HIV, TB, antibiotic resistance)?	☐ Yes ☐ No	
Substance dependency?	☐ Yes ☐ No	
Kidney problems?	☐ Yes ☐ No	
Anaesthesia / sedation problems (you or close family)?	☐ Yes ☐ No	
Head, neck, face, jaw, throat or nose problems?	☐ Yes ☐ No	
Mental health conditions?	☐ Yes ☐ No	
Endocrine problems (thyroid / adrenal / pituitary)?	☐ Yes ☐ No	

LUNG, BREATHING & SLEEPING PROBLEMS

☐ Asthma / Bronchitis ☐ Obstructive Sleep Apnoea / Snoring ☐ Shortness of breath ☐ Other

DETAILS (IF ANY APPLY)

HEART & CIRCULATION PROBLEMS

☐ High blood pressure ☐ Heart attacks or angina ☐ Irregular heart beat ☐ Pacemaker / Defib / Implant / Stent ☐ Other

DETAILS (IF ANY APPLY)

OTHER MEDICAL CONDITIONS OR RELEVANT INFORMATION

Operations & Procedures

#	DESCRIPTION	YEAR
1		
2		
3		
4		
5		
6		

Family History of Cancer

Any close family had cancer? ☐ Yes ☐ No

If yes, specify type of cancer and age of diagnosis if known.

FATHER	
FATHER'S PARENTS	
PATERNAL AUNTS/UNCLES	
MOTHER	
MOTHER'S PARENTS	
MATERNAL AUNTS/UNCLES	
CHILDREN	
BROTHERS/SISTERS	
OTHER	

Terms & Conditions

> You are welcome to bring a support person to your consultation and to request a chaperone for any examination. Please let us know if you require any additional support, for example an interpreter — your comfort is our priority. Your care may need to be transferred to another clinician or hospital; we will inform you if this is required.

Consent to Share Information — I authorise Intus Specialist Health Care to disclose relevant clinical information to ACC and my insurance provider for claims and approvals. Only necessary information will be shared, in accordance with privacy regulations.

☐ **I consent to sharing information with ACC and my insurer. ***

Payment — Consultation and endoscopy payments are due at the end of your appointment (contact your insurer for prior approval). Surgical procedures are invoiced after the event. I am responsible for confirming my eligibility and any excess/shortfall with my insurer.

☐ **I acknowledge the payment terms above. ***

Cancellation / No-Show Policy — available at www.intus.co.nz/care-at-intus/cancellation-non-attendance

☐ **I acknowledge and agree to the Intus Cancellation Policy. ***

Health New Zealand / Te Whatu Ora referrals: no payment required — covered by Health NZ/Te Whatu Ora.

Privacy Policy — available at www.intus.co.nz/privacy-statement. Information is collected, used and stored per the Health Information Privacy Code 2020 and Privacy Act 2020. You may request access to/correction of your information; declining to provide information may impact your care.

☐ **I accept the privacy policy and understand my rights. ***

AI Technology Use — Intus may use AI tools to assist with administration, transcription and documentation. These tools do not make clinical decisions and are reviewed by clinicians/staff. See www.intus.co.nz/heidi-health-information.

Do you consent to the use of AI technology where appropriate? *

☐ Yes ☐ No

SIGNATURE * _____ **PRINT FULL NAME *** _____ **DATE** _____

Office use only — Date received: _____ Entered by: _____ NHI confirmed: ☐