Harbour Surgery Centre

Level 1, Northern Clinic
Southern Cross North Harbour
Entry A, 212 Wairau Road
Wairau Valley, Auckland 0627

PATIENT INFORMATION SHEET

File No. _____ Primary Surgeon _____ NHI _____

Surname _____ Mr | Mrs | Miss | Ms | Dr

First Name(s) [Legal] _____

[Preferred] _____

Home Address _____

_____ Post Code _____

Postal Address _____ Post Code _____

Date of Birth _____ New Zealand Resident YES | NO

Occupation _____

Contact Numbers • Mobile _____ • Home _____

• Email _____

Contact Person / Next of Kin • Name _____ • Relationship _____

• Telephone _____

Medications and Supplements _____

_____

Allergies _____

General Practitioner _____

Referred By (If not GP) _____

Medical Insurance: Southern Cross | NIB | AIA | Partners Life | Other: _____

Health Insurance Membership Number: _____

Depending on your policy, our consultation fee may be able to be claimed directly with Southern Cross [Please note a shortfall may apply].

ACC Claim Number _____ Date of Injury _____

Note: ACC may not cover the full cost of the consultation. A surcharge may apply, payable on the day of your consultation.

I hereby understand and give my consent for Harbour Surgery Centre to access any relevant medical information and for Harbour Surgery Centre to disclose relevant medical information to my insurer to determine eligibility of cover under my insurance policy and to authorise, process and settle claims.

Signature _____ Date _____

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