A TRADITION OF EXCELLENCE

ST GEORGE'S EYE CARE

St George's Eye Care Booking Form

Main Hospital Entrance off Heaton Street

T: +64 3 375 6333
F: +64 3 375 6332
E: eyecarebookings@stgeorges.org.nz
W: www.stgeorgeseyecare.org.nz

Canon Wilford Wing
249 Papanui Rd, Strowan, Christchurch 8014
Private Bag 4737, Christchurch 8140

For Office Use Only

APPOINTMENT DATE: _____

APPOINTMENT TIME: _____

NHI NUMBER: _____

CLINICIAN: _____

Personal Details (to be completed by patient or guardian)

Given Names: _____ Preferred Name: _____

Previous / Maiden Names: _____ Occupation: _____

Address: _____ Phone: _____

Suburb: _____ Work: _____

City: _____ Mobile/Alternative: _____

Email: _____

Date of Birth: _____ Gender: Female ☐ Male ☐

GP: _____ Optometrist: _____

Insurance Company: _____ Policy Number: _____

THIS INFORMATION IS REQUIRED FOR STATISTICAL PURPOSES

Country of Birth: _____ New Zealand Resident: Yes ☐ No ☐

First Language *(If not English)*: _____ Do you require a Translator: Yes ☐ No ☐

Choose the box(es) that apply to you:

NZ Maori	☐	New Zealander	☐	Other European	☐	Samoan	☐
Cook Island Maori	☐	Tongan	☐	Niuean	☐	Tokelauan	☐
Fijian	☐	Other Pacific	☐	Indian	☐	Other Asian	☐
South East Asian	☐	Chinese	☐	Other	☐	Not Stated	☐

Please list specific ethnicity of not listed above: _____

Contact – Next of Kin Details

Contact Name: _____ Relationship: _____

Address: _____

Home phone: _____ Work/mobile phone: _____

Alternative Contact Name: _____ Telephone: _____

Comments:

_____

_____

_____

Privacy Information

St George's Eye Care will collect and store information about you that is necessary for your treatment and will only use the information for that intended purpose.

I consent to allow St George's Eye Care to:

- Pass on information to Government entities (such as the Ministry of Health) if they are legally entitled to it, or if it is necessary or my treatment and care (such as a Public Hospital).
- Share relevant information related to my healthcare as required by third parties, such as my Health Insurer, Medical Specialists or General Practitioner.
- I consent to the above and confirm to the best of my knowledge that the information supplied is correct.

Print name in full: _____

Signed: _____ Date: _____

If not the patient, state relationship to patient: _____

Email Use

I consent to allow St George's Eye Care to use email to:

Pass on information to Government entities (such as the Ministry of Health) if they are legally entitled to it, or if it is necessary for my treatment and care (such as a Public Hospital).

Share relevant information related to my healthcare as required by third parties, such as my Health Insurer, Medical Specialists or General Practitioner.

I accept that St George's Eye Care is committed to protecting the privacy of individuals who submit their email address and other identifying details however email transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses.

Print name in full: _____

Signed: _____ Date: _____