ST GEORGE'S HOSPITAL
A TRADITION OF EXCELLENCE

ST GEORGE'S EYE CARE

St George's Eye Care Booking Form

Please complete the personal details below

Personal details - (to be filled in by patient or parent/guardian) (no labels)

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mstr Other: _____ Gender: _____

Surname: _____ Given names: _____

Preferred name: _____ Any previous name(s): _____

Date of birth: _____ Occupation (optional): _____

Physical address: _____ Postal address (if different to physical): _____

_____ _____

_____ Postcode: _____ _____ Postcode: _____

Contact phone number: _____ Email: _____

Surgeon / Clinician: _____ GP name: _____

Practice: _____

NZ resident: ☐ Yes ☐ No

Ethnicity (choose up to 3 if applicable) ☐ New Zealand European ☐ Māori – iwi _____

☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian ☐ Other Asian

Other - Please state: _____

Next of kin / emergency contact (please make sure they are aware of your admission to hospital)

Name: _____ Contact number: _____

Relationship to patient: _____

How did you hear about St George's Eye Care? *Choose the box(es) that apply to you:*

Optometrist ☐ GP ☐ Radio/Newstalk ZB ☐ Google Search ☐

Magazine ☐ Family/Friends ☐ Other ☐

Please list if not listed above: _____

St George's Eye Care payment details

How will your consultation be paid for? *(tick and complete as many as apply)*

☐ **Medical Insurance**

Name of medical insurance company: _____ Membership No. _____

☐ **ACC** ☐ **DHB** ☐ **Personal Payment**

Conditions of payment

I understand that I am responsible for any outstanding balance that is not fully covered by ACC, insurance or another funder.
I agree to settle the balance of my account in full within 7 days of invoice date if the account is being paid personally, unless prior arrangements have been agreed.
I understand Eye Care may release such details concerning me to third parties for the sole purpose of collecting any outstanding fees that are owed to the hospital. This may include obtaining my current credit status.
Eye Care may instruct a debt collection agency to recover any outstanding balances. I understand I am responsible for all costs and expenses incurred in recovering these.
I have read, understood and agree to the above conditions and I agree to make payment as set out above.

Your health information

We are required to collect and store information about you, we will:

1. Collect information only when necessary for your treatment
2. Use information for its intended purpose only (i.e. treatment, administration, teaching, research, ongoing care)
3. Keep information securely in your medical file, electronic system or a third party certified storage facility
4. Pass on to government bodies only that information to which they are legally entitled
5. Make your information available, and enable you to request corrections if you think your information is inaccurate
6. Obtain any information relating to the approval/claim for this admission from any medical insurance company
7. Provide information relating to the type of procedure to ACC or any medical insurance company

I give permission to St George's Eye Care, or any independent health clinician involved in my care during this admission, to access health information about me that is relevant to my current treatment. Such information may be held by St George's Eye Care, other health professionals or other health organisations.

Signature: _____ Name: _____ Date: _____