MacMurray CENTRE
Digestive Diseases & Endoscopy

Patient Particulars

Please bring the completed form to the MacMurray Centre on the day of your procedure.

Surname:	Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other ☐		
First Names:		Preferred Name:	
Address: (Normal place of residence)			
Town / City:		Post Code:	
New Zealand Resident:	Yes ☐ No ☐		
Home Phone No:		Date of Birth:	
Business Phone No:		Age:	
Mobile Phone No:		Gender:	Male ☐ Female ☐
Email:			
	Please note that the MacMurray Centre will on use your email address for private correpondence.		
Ethnicity:		Occupation:	
General Practitioner:		Referring Doctor:	
Have you been a patient at the **MacMurray Centre** before?		Yes ☐ No ☐	
Contact Person: (Full Name)		Relationship:	
Address:			
Town / City:		Home Phone No:	
Business Phone No:		Mobile Phone No:	

Accounts are payable on completion of procedure

Should I default on any payment due by me to MacMurray Centre, ongoing unpaid accounts may incur collection fees.

Medical Insurance

Please make your own approval and payment arrangements with your insurer prior to your procedure, unless you are insured with Southern Cross.

Medical Insurer:			
Policy Number:		Prior Approval Number:	

How did you hear about us?	

It is important that the information supplied to the MacMurray Centre is accurate and up to date.

This information will be kept securely and may be accessed or corrected at any time by contracting the MacMurray Centre.

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Pre Procedure Information		
Yes No (√) Patient History		Details
☐ ☐	Heart Disease / Previous Endocarditis / Arrhythmias (please circle)	
☐ ☐	Heart Valve Disease / Replacement Rheumatic Fever (please circle)	
☐ ☐	CVA / Stroke (please circle)	
☐ ☐	Liver Disease / Urinary Retention / Prostate Problems (please circle)	
☐ ☐	Kidney Disease	
☐ ☐	Organ Transplant / Immunosuppression (please circle)	
☐ ☐	Diabetes Type 1 ☐ Type 2 ☐	
☐ ☐	Respiratory Disease	
☐ ☐	Current / Recent Chemotherapy (please circle)	
☐ ☐	Seizure Disorders	
☐ ☐	Hypertension (High Blood Pressure)	
☐ ☐	Clotting Disorder (Bleeding Tendencies)	
☐ ☐	Hip / Knee Replacement (≤ 6 months ago) or Prosthetic Implants	
☐ ☐	Pregnant / Breastfeeding (please circle)	
☐ ☐	Glaucoma	
☐ ☐	Infectious Diseases	
☐ ☐	Previous Abdominal Surgery / Procedures	
☐ ☐	Other	
Current Medications		
☐ ☐	Insulin	
☐ ☐	Warfarin	
☐ ☐	Aspirin Based Products	
☐ ☐	Other (please list):	
☐ ☐	Allergies / Known Sensitivities	
☐ ☐	Do you normally require antibiotics for dental procedures?	
Personal Preferences		
☐ ☐	Do you have any specific cultural practices we need to be aware of?	
☐ ☐	Do you have any dietary restrictions?	

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