Practice Enrolment Form

Highland Park Medical Centre

14 Highland Park Drive, Highland Park, Auckland, 2010

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Legal Name	**Title:**	**Surname:**	**First Name:**
			Middle Name:

NHI: (office use only)	**Date of birth:**
Gender: ☐ Male ☐ Female ☐ Gender Diverse *(please state)*	**Place of birth:**
Occupation:	**Country of birth:**

Community Services Card	**High User Health Card**
☐ **Yes** / ☐ **No**	☐ **Yes** / ☐ **No**
Card number:	**Card number:**
Card Expiry Date:	**Card Expiry Date:**

Residential Address	**Street Number:**	**Street Name:**	
	Suburb:	**City:**	**Postcode:**
Postal address *(if different to above)*			

Home Phone:	**Work:**	**Mobile:**

Email:		**Emergency Contact Name:**
Do you agree to receive emails:	☐ **Yes** ☐ **No**	**Relationship:** **Tel. contact:**

Do you agree to receive text messages?	☐ **Yes** ☐ **No**	**Do you Smoke?**	☐ **Yes** ☐ **No (ex smoker)** ☐ **Never**

Which ethnic group(s) do you belong to? Tick the space or spaces which apply to you

- ○ New Zealand European
- ○ Maori
- ○ Samoan
- ○ Cook Island Maori
- ○ Tongan
- ○ Niuean
- ○ Chinese
- ○ Indian
- ○ Other such as (Dutch, Japanese, Tokelauan)

Please state ______________________________

Transfer of records

In order to get the best care possible, I agree to this Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register.

☐ Yes ☐ No ☐ Not applicable

Previous Doctor's name:
Address:

Phone:

Signature ______________________________________

(agreement for transfer of records)

For Office Use Only	Entered	NHI	NEWPC	NES Enrolment	NES Base Info	W Visa Task / Alert	Faxed	Checked	Scanned

Please turn over

My declaration of entitlement and eligibility

I am entitled to enrol because I am residing permanently in New Zealand *The definition of residing permanently in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months*	☐

I am eligible to enrol because:

A	I am a New Zealand citizen *(If yes, tick box and proceed to **I confirm that, if requested, I can provide proof of my eligibility** below)*	☐

If you are **not a New Zealand Citizen**, please tick which eligibility criteria applies to you (B-J) below:

B	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	☐
C	I am an Australian citizen or Australian permanent resident **AND** able to show I have been in New Zealand or intend to stay in New Zealand for at least 2 consecutive years	☐
D	I have a work visa/permit and can show that I am able to be in New Zealand for at least 2 years (previous permits included)	☐
E	I am an interim visa holder who was eligible immediately before my interim visa started	☐
F	I am a refugee or protected person **OR** in the process of applying for, or appealing refugee or protection status, **OR** a victim or suspected victim of people trafficking	☐
G	I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one criterion in clauses a – f above **OR** in the control of the Chief Executive of the Ministry of Social Development	☐
H	I am a NZ Aid Programme student studying in NZ and receiving Official Development Assistance funding (or their partner or child under 18 years old)	☐
I	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	☐
J	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship fund	☐

I confirm that, if requested, I can provide proof of my eligibility	☐
we will retain a copy for eligibility purposes only Evidence Sighted (office use only)	☐

My agreement to the enrolment process

NB Parent or caregiver to sign if you are under 16 years

→ **I intend to use this practice** as my regular and ongoing provider of general practice/GP/health care services.

→ **I understand** that by enrolling with this practice I will be included in the enrolled population of East Health Trust Primary Health Organisation, and my name, address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers.

→ **I understand** that if I visit another health care provider where I am not enrolled I may be charged a higher fee.

→ **I have been given information** about the benefits and implications of enrolment and the services this practice and PHO provides along with the PHO's name and contact details.

→ **I have read and I agree** with the Use of Health Information Statement. The information I have provided on the Enrolment Form will be used to determine eligibility to receive publicly-funded services. Information may be compared with other government agencies, but only when permitted under the Privacy Act.

→ **I understand** that the Practice participates in a national survey about people's health care experience and how their overall care is managed. Taking part is voluntary and all responses will be anonymous. I can decline the survey or opt out of the survey by informing the Practice. The survey provides important information that is used to improve health services.

→ **I agree** to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

Signatory Details	Signature ________________________	Date ___/___/_____	☐ Self-Signing	☐ Authority

An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf

Authority Details *(where signatory is not the enrolling person)*	**Full Name:**	**Relationship:**
	Contact Phone:	**Basis of authority:** *(e.g. parent of a child under 16 years of age)*

Highland Park Medical

PATIENT REGISTRATION FORM PART 2

Full Name: ____

PREFERRED NAME:_________________________________ Date of Birth: _____________________________

Hapu / Iwi ____________________________ Or **N/A**

Employer:____Occupation__________________________________

Employers address: ____

Do you have medical insurance?

Do you have a High Use Health Card? **Please show receptionist**

Do you have a Community Services Card? **Please show receptionist**

Do you have any allergies to medication ? Yes / No

Please list____

Do you suffer any ongoing medical illness or disability? Yes / No

Please state ____

Have you been admitted to hospital in NZ? Yes / No State when _______________________________

Have you had any operations? Yes / No Please list ____

Has anybody in your immediate family (parent / sibling / children) been diagnosed with any significant health problem? eg diabetes, heart disease, high blood pressure, asthma, breast cancer, bowel cancer, hepatitis B, TB

____

Would you like smoking cessation advice Yes / No (only if a smoker)

Alcohol Intake : Nil / Minimal / Mild / Moderate / More

When was your most recent tetanus injection? ____

Women Only: When did you have your last smear? ____

Have you had an abnormal smear? Yes / No ___________________________________

Have you had a mammogram? Yes / No ____

Where did you hear about us...

Terms of Trade:
In line with normal business practices, ***payment is expected at the time of doctor consultation****. Any cost incurred in recovering any outstanding balance will be payable by you, including all legal charges. If the account remains unpaid the patient consents to personal details relevant to the actual account being passed on to the recovery agent.*
I agree to Highland Park Medical sending me information relevant to my health, which may include recall letters for health screening.

THE INFORMATION GIVEN IS TRUE TO MY KNOWLEDGE AND I ACCEPT THE TERMS OF PAYMENT

SIGNATURE OF PATIENT _______________________________________ ***(OR PARENT OR GUARDIAN)***

Please turn over

Email and mobile phone communications consent form

I agree to the following terms and conditions when subscribing to electronic mail (email)/ cellphone text communication with the staff at Highland Park Medical Centre.

The email address/cell phone number I have provided is my own and therefore only I have access to my messages. Where the email address is shared, I give consent for messages sent from this practice to be potentially shared by others who have access to my email account/mobile phone.

It is my responsibility to maintain the privacy of any emails/texts sent from Highland Park Medical Centre to my email address/mobile phone.

I will not send unsolicited spam messages. I agree to abide by The Unsolicited Electronic Messages Act 2007.

I give consent to Highland Park Medical Centre sending me emails/texts. This includes and is not limited to laboratory and radiology results, reminders for screening examinations/investigations, appointment reminders, invoices and newsletters.

I reserve the right to withdraw my email address/mobile number from Highland Park Medical Centre's database. I will, however, state this clearly to Highland Park Medical Centre if I decide to do this.

It is my responsibility to inform Highland Park Medical Centre if I change my email address/mobile phone number.

If you have changed your home/work telephone number/address please let us know by writing the changes below:

Home phone number:

Work phone number:

Address:

Current email address:

Current mobile phone number:

Signed: *Name*

Date

<u>Preferred means of contact with you: Circle one</u>

Home phone Work Phone Mobile Phone Email Txt Message