Practice Enrolment Form

Highland Park Medical Centre

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EAST HEALTH TRUST
primary health organisation

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
☐ **Yes** / ☐ **No**
Card number:
Card Expiry Date:

High User Health Card
☐ **Yes** / ☐ **No**
Card number:
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 Smoke? ☐ **Yes** ☐ **No (ex smoker)** When did you stop? _____ ☐ **Never**

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

- ○ New Zealand European
- ○ Māori
- ○ Samoan
- ○ Cook Island Māori
- ○ 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)

Iwi	**If of Māori decent, please enter up to 3 iwi or home area affiliations**	**Iwi 1** _____	**Iwi 2** _____	**Iwi 3** _____

For Office Use Only	Entered	NHI	Enrol	Ex Smoker Date	Portal	Visa Task / Alert	Faxed	Newpc	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

Preferred Name _____

Occupation _____ **Employer** _____

Do you have medical insurance?

◯ Yes ◯ No Provider

Do you have a preferred pharmacy we can send scripts to?

◯ Yes ◯ No Unichem Highland Park Pharmacy **OR state**

Do you have any allergies? (food or medication)

◯ Yes ◯ No Please state

Have you had any operations?

◯ Yes ◯ No State when and why

If you are a smoker, would you like smoking cessation advice?

◯ Yes ◯ No

How often do you have a drink that contains alcohol?

◯ Never ◯ Monthly or less ◯ 2-4 times per mth ◯ 2-3 times per week ◯ 4+ times per week

How many standard alcohol drinks do you have on a typical day when you are drinking?

◯ 1 - 2 ◯ 3 - 4 ◯ 5 - 6 ◯ 7 - 9 ◯ 10+

How often do you have 6 or more standard drinks on one occasion?

◯ Never ◯ Less than monthly ◯ Monthly ◯ Weekly ◯ Daily or almost daily

Do you have any, or have had any of the following medical Problems?
Or is there a family history of the following?

	Self	Family		Self	Family
Diabetes	◯ Yes	◯ Yes	Blood clot	◯ Yes	◯ Yes
High blood pressure	◯ Yes	◯ Yes	Stroke	◯ Yes	◯ Yes
Heart disease or problems	◯ Yes	◯ Yes	High cholesterol	◯ Yes	◯ Yes
Heart Attack	◯ Yes	◯ Yes	Migrane	◯ Yes	◯ Yes
Asthma	◯ Yes	◯ Yes	Epilepsy	◯ Yes	◯ Yes
Other lung or respiratory disease or problem	◯ Yes	◯ Yes	Breast cancer	◯ Yes	◯ Yes
Kidney disease or problem	◯ Yes	◯ Yes	Other cancer	◯ Yes	◯ Yes
Liver disease or Hepatitis	◯ Yes	◯ Yes	Glaucoma	◯ Yes	◯ Yes
Bowel Disease or problems	◯ Yes	◯ Yes	Rheumatic Fever	◯ Yes	◯ Yes
Joint disease or problems, arthritis	◯ Yes	◯ Yes	Tuberculosis (TB)	◯ Yes	◯ Yes
Depression and/or anxiety	◯ Yes	◯ Yes	Eczema	◯ Yes	◯ Yes
Other mental health illnesses	◯ Yes	◯ Yes	Hay fever	◯ Yes	◯ Yes

Falls assessment - 75yrs and over	
Have you slipped, tripped or fallen in the last 12 months?	◯ Yes ◯ No
Do you need to use your hands to get out of a chair?	◯ Yes ◯ No
Are there some activities you have stopped doing because you are afraid you might lose your balance? Do you worry about falling?	◯ Yes ◯ No
Do you use a walking frame?	◯ Yes ◯ No
Do you receive help with washing / showering and dressing?	◯ Yes ◯ No

PTO

Email and mobile phone communications consent

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.

Consent to receive TEXTS	◯ **Yes** ◯ **No**	**Consent to receive EMAILS**	◯ **Yes** ◯ **No**

First / preferred method of contact with you:

Tick just ONE

◯ **Home phone** ◯ **Work Phone** ◯ **Mobile Phone** ◯ **Email** ◯ **Txt Message**

Patient Portal:

The portal gives you access to appointment booking, easy messaging with the clinic, ability to request prescriptions, check your results, see what immunisations are on record and what you might need, any recalls in place for health screening and much more. You can access the portal by your web browser or on a free App on your iOS or Android device.
If you have children under 16yrs you will be able to book appointment for them using the portal.

Please note: ***To register you must be over 16 and not share an email address with anyone.***

Register for patient portal	◯ **Yes** ◯ **No** ◯ **Under 16**

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.*

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

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

NAME: _____ ***DATE:*** _____