GREENWOOD MEDICAL CENTRE	ENROLMENT FORM	Doctor to Be Enrolled with : _____

641 Manukau Road Epsom 1023 Ph. 09 625 6173	To be Enrolled YES/NO Re Enrolment YES/NO	NHI

Name	(Title)	Given Name	Other Given Name(s))	Family Name
Other Name(s) (eg. maiden name) Please tick the name you prefer to be known as				
Birth Details		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender	☐ Male ☐ Female ☐ Gender diverse (please state)			Occupation

Usual Residential Address	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

Contact Details	Mobile Phone	Home Phone	Email Address	
Emergency Contact	Name		Relationship	Mobile (or other) Phone

Transfer of Records	*In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register.*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Address / Location	

Ethnicity Details 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	**Community Services Card** ☐ Yes ☐ No Day / Month / Year of Expiry — Card Number **High User Health Card** ☐ Yes ☐ No Day / Month / Year of Expiry — Card Number **Do you Smoke?** ☐ Yes ☐ No (ex- smoker) ☐ Never Comments

PLEASE TURN OVER TO COMPLETE MANDATORY INFORMATION

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	☐	Evidence sighted (*Office use only*)

My agreement to the enrolment process

NB. Parent or Caregiver to sign if you are under 16 years

I (and my family members shown)intend to use this practice as my regular and on-going provider of general practice / GP / health care services.

I (and my family members shown) understand that by enrolling with this practice, I will be included in the enrolled population with the Primary Health Organisation (PHO) this practice belongs to, 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 our contact details and entitlement and/or eligibility to be enrolled.

I understand that this practice is entitled to charge a fee for health services it provides and that I **AGREE TO PAY SUCH COSTS AT THE TIME OF CONSULTATION** or additional costs associated with the collection of unpaid accounts.

Signatory Details	Signature	Day / Month / Year	☐ 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)		

DEPENDANTS TO BE ENROLLED WITH THIS ENROLMENT

Authorised representatives can enrol dependants. In the case of a dependant child under 16, the process can be completed by a parent or caregiver who is the legal guardian or who has custody.

NHI	First names	Family name	Gender	Ethnicity	Date Of Birth	Country Of Birth

Authority Details	Full Name	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age)		

Signatory Details	Signature	Day / Month / Year

Office Use Only	**Date**	**Initial**
Entered into Medtech		
NHI Obtained		
Enrolment Form Scanned		
Notes Requested By Fax		
Notes Entered Into Medtech		
Entered in Book		

Health Information Privacy Statement

It is compulsory for general practices to ask you to read and agree to this statement before signing the enrolment form. Once you have read it, please tick the corresponding box on your enrolment form and sign it.

I understand the following:

Access to my health information

I have the right to access (and have corrected) my health information under Rules 6 and 7 of the Health Information Privacy Code 1994.

Visiting another GP

If I visit another GP who is not my regular doctor I will be asked for permission to share information from the visit with my regular doctor or practice.

If I have a High User Health Card or Community Services Card and I visit another GP who is not my regular doctor, he/ she can make a claim for a subsidy, and the practice I am enrolled in will be informed of the date of that visit. The name of the practice I visited and the reason(s) for the visit will not be disclosed unless I give my consent.

Patient enrolment information (enrolled patients only)

The information I have provided on the Practice enrolment form will be:

- held by the practice
- used by the Ministry of Health to give me a National Health Index (NHI) number, or update any changes
- sent to the PHO and Ministry of Health to obtain subsidised funding on my behalf
- 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.

Health information

Members of my health team may:

- add to my health record during any services provided to me and use that information to provide appropriate care
- send relevant health information to other health professionals who are directly involved in my care.

Audit

In the case of financial audits, my health information may be reviewed by an auditor for checking a financial claim made by the practice, but only according to the terms and conditions of section 22G of the Health Act (or any subsequent applicable Act). I may be contacted by the auditor to check that services have been received. If the audit involves checking on health matters, an appropriately qualified health care practitioner will view the health records.

Health programmes

Health data relevant to a programme in which I am enrolled (e.g., breast screening, immunisation, diabetes) may be sent to the PHO or the external health agency managing this programme.

Other uses of health information

Health information which will not include my name but may include my National Health Index Identifier (NHI) may be used by health agencies such as the district health board, Ministry of Health or PHO for the following purposes, as long as it is not used or published in a way that can identify me:

- health service planning and reporting
- monitoring service quality
- payment.

Research

My health information may be used for health research, but only if this has been approved by an Ethics Committee and will not be used or published in a way that can identify me. Except as listed above, I understand that details about my health status or the services I have received will remain confidential within the medical practice unless I give specific consent for them to be communicated

Greenwood Medical Centre

New Patient Medical Questionnaire

Name_____**DOB**____/____/____

1. Do you have any of the below medical conditions? Or is there a family history?

	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 <60yrs	□ Yes	□ Yes	Migraine	□ Yes	□ Yes
>60yrs	□ Yes	□ Yes	Epilepsy	□ Yes	□ Yes
Asthma	□ Yes	□ Yes	Breast cancer	□ Yes	□ Yes
Any lung problem or	□ Yes	□ Yes	Prostate cancer	□ Yes	□ Yes
Respiratory disease	□ Yes	□ Yes	Other cancer	□ Yes	□ Yes
Kidney disease or problem	□ Yes	□ Yes	Glaucoma	□ Yes	□ Yes
Liver disease or hepatitis	□ Yes	□ Yes	Rhuematic Fever	□ Yes	□ Yes
Bowel disease or problems	□ Yes	□ Yes	Tuberculosis (TB)	□ Yes	□ Yes
Joint disease or problems, athritis	□ Yes	□ Yes	Eczema	□ Yes	□ Yes
Depression/Anxiety	□ Yes	□ Yes	Hay Fever	□ Yes	□ Yes
Other mental illness	□ Yes	□ Yes	Food allergies	□ Yes	□ Yes

2. Do you have any **other health, disability problems or inherited conditions?** *-please list*

3. Please list **all medication** you currently take:

4. Have you had any operations? *-if yes please list* □ Yes □ No

5. Are you **allergic to any medication**? *-if yes please list* □ Yes □ No

6. Do you smoke? □ Yes □ No If yes how many/day_____

If yes would you like any help to quit? □ Yes □ No

Have you ever smoked? □ Yes □ No If yes when did you quit?_____

7. Do you drink alcohol? □ Yes □ No If yes how many/week?_____

8. Do you have any **substance abuse problems**? □ Yes □ No what type of alcohol?_____

9. Have you ever experienced domestic abuse or violence? □ Yes □ No

10. Question for **women:**

When was your last cervical smear? _____

Have you ever had a abnormal smear? □ Yes □ No

Have you had a mammogram (those over 40 years)? □ Yes □ No □ N/A

11. When was your last tetanus booster?_____

12. Are your child immunisations up-to-date? □ Yes □ No

Signed:_____ Date: _____