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| P:\OHL Group Files\OMNI HEALTH\All other Omni\Omni Enrolment Forms\NES Enrolments (updated 07.12.16)\Pinnacle Logo.png | **PATIENT ENROLMENT FORM** | 13/17 Nobs Line, Strandon, New Plymouth**P**: 06 769 9567 **F**: 06 769 9569**E:admin@strandonhealth.co.nz** |

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| **Provider: GP2GP*:* EDI: strandon****Dr F Terblanche: NZMC 35798 Dr K Dalton: NZMC 58837 Dr B Myers: NZMC 49944** |  |
| NHI *(Office use only)* |

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| **Name**  |  |  |  |  |
| (Title) | Given Name\* | Other Given Name(s)\* | Family Name\* |
| **Preferred Name/****Maiden name** |  |  |  |
|  |
| **Birth Details**  |  |  |  |
| Day / Month / Year of Birth\* | Place of Birth\* | Country of birth\* |
| **Gender** |  |  |  | Employer Name/AddressOccupation |
| Male\* | Female\* | Gender diverse (please state) \* |
| **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 |
|  |  | **Do you agree to receive text messages?** | Yes | No |
| **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?\***Smoking status (if over 15) Never smoked 🞎 Ex-smoker 🞎 Greater than 15months🞎 less than 12 months 🞎 Current smoker 🞎Would you like support to quit? Yes 🞎 No 🞎 |
| **Do you have medical insurance?** | Yes | No |
| Card Number |  |

Primary Health Services Provider Enrolment Form Last Updated : 11 March 2020

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| **My declaration of entitlement and eligibility** |

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| **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:

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| 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:

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| 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 |  |

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| **I confirm** that, if requested, I can provide proof of my eligibility |  | Evidence sighted (*Office use only*) |

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| **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 on-going provider of general practice / GP / health care services.

**I understand** that by enrolling with this practice, I will be included in the enrolled population with **Midlands Regional Health Network Charitable Trust**, 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 my contact details and entitlement and/or eligibility to be enrolled.

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| **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.***

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

Health Questionnaire

**Enrolled Patients**

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| FULL NAME |  | DATE OF BIRTH DD / MM / YYYY |
| OCCUPATION |  | HEIGHT |  | WEIGHT |  | BP |  |
| Do you take any regular medication/supplements? Yes / No Please specify... |
| Do you have any allergies (food/medications/latex)? Yes / No Please specify... |
| Do you smoke? Yes / No If yes, how many? Please specify... |
| Have you ever smoked? Yes / No If yes, when did you quit? Please specify... |
| Would you like support to quit? Yes / No Continue being smokefree? Yes / No |
| Do you drink alcohol? Yes / No If yes, how many std. drinks a week? |
| Do you use recreational drugs? Yes / No / Declined |
| Do you exercise? Never / Seldom / Occasionally / Regularly |
| What are your weekly work hours? <20hrs / 20-40hrs / >40hrs |
| Have you had a cervical smear? Yes / No When? Please specify... |
| Was it ever abnormal? Yes / No |
| Have you had a mammogram? Yes / No When? Please specify... |
| Was it ever abnormal? Yes / No |
| Have you had a prostate screening? Yes / No When? Please specify... |
| Was it ever abnormal? Yes / No |

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| FAMILY HISTORY | Have any of your immediate family members had any of the following? |
| Cardiac Issues: | Yes | / No | Respiratory Issues: | Yes | / No |
| Mental Health Issues: | Yes | / No | Diabetes: | Yes | / No |
| Cancer: Please specify... |
| Other Significant Family History: Please specify... |

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| PERSONAL HISTORY | Do you currently have (or ever had) any of the following? |
| Complete with nurse: |
| Cardiac Issues Yes | / No | Respiratory Issues: Yes / No |
| Gastrointestinal/Bowel Disease: Yes | / No | Liver Disease: Yes / No |
| Kidney Disease: Yes | / No | Thyroid Disease: Yes / No |
| Neurological (Seizures/Epilepsy): Yes | / No | Mental Health Issues: Yes / No |
| Diabetes: Yes | / No | Dermatology Issues: Yes / No |
| Cancer: Please specify... |  | Significant Surgery: Please specify... |
| Did you receive childhood immunisations? |  | Yes / No |
| When was your last tetanus immunisation? Please specify... |
| Other Significant History: Please specify... |