PATIENT ENROLMENT FORM

EDI Number	Address	Phone Number	Fax Number	NHI *(Office use only)*

Legal Name	(Title)	Given Name	Other Given Name(s))	Family Name
Other Name(s) (e.g. 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

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

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

Patient Survey

From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.

Patient Survey Contact Details: As provided above ☐ (or)

Alternative Mobile Phone

Alternative Email Address

☐ I do not wish to particlpate in the Patient Survey

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

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)		

Blockhouse Bay Medical Centre Health Questionnaire

Please answer as fully as possible. Please ask for help to fill in the form if needed.

PERSONAL DETAILS

Family Name

First Name (s)

Preferred Name

Gender ☐ Male ☐ Female

Date of Birth

Completed by:

PAST MEDICAL HISTORY: Have you ever had any of the following?

☐ Asthma ☐ Eczema ☐ Depression ☐ Epilepsy ☐ Migraine

☐ Tuberculosis ☐ Heart Disease ☐ Stomach ulcer ☐ Blood disorders ☐ Diabetes

☐ Rheumatic Fever ☐ Mental Illness ☐ Other:

DISABILITY

√ Do you have a disability? ☐ Yes ☐ No

If yes, please state:

MEDICATION

√ Do you take any regular medication? ☐ Yes ☐ No

If yes, please state:

ALLERGIES

√ Are you allergic to any tablets, medications or injections? ☐ Yes ☐ No

√ Do you have any other allergies? ☐ Yes ☐ No

If yes, please state:

GENERAL HEALTH QUESTIONS

√ Have you ever smoked tobacco? ☐ Yes ☐ No

√ If yes, are you? ☐ A current smoker ☐ Ex smoker (past 12months) ☐ Long term ex smoker

√ Do you drink alcohol? ☐ Yes ☐ No

If yes, √ how often? ☐ Once a month or less ☐ 2 – 4 times a month ☐ 2 -3 times a week ☐ 4 or more times a week

How many drinks per session? ☐

√ How often do you have more than 6 or more standard drinks per session? ☐ Never

☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily

FAMILY HISTORY

√ Has any immediate family member (mother, father, brother, sister) had any of these conditions/diseases?

☐ Asthma ☐ Migraine ☐ Heart Disease ☐ High blood pressure ☐ Cancer

☐ Tuberculosis ☐ Thrombosis ☐ Mental Illness ☐ Stroke ☐ Diabetes

☐ Epilepsy ☐ Osteoporosis ☐ Other:

FEMALE PATIENTS ONLY

Complete if applicable

When was your last cervical smear Result was: Normal ☐ Abnormal ☐

When was your last mammogram Result was: Normal ☐ Abnormal ☐

PAST VACCINATION HISTORY

√Have you been vaccinated against Tetanus ☐ No ☐ Yes What year?

Do you have an annual flu vaccination? ☐ No ☐ Yes Date last vaccination

Have you had any travel vaccines? ☐ No ☐ Yes Specify

Signature: Date: