PATIENT ENROLMENT FORM

ProCARE

Practice Name* Mt Eden Village Doctors
431 A Mt Eden Rd, Mt Eden
Auckland 1024
Ph: 6306981

Phone Number 09 6306981

Address

EDI Number goodshks

DR MARGARET SHANKS #10279

Fax Number 09 630 6982

Fields with * are compulsory	*Anyone over age of 16 years must complete their own enrolment form*	NHI *(Office use only)*

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 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 of the Primary Health Organisation 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.

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
Authority Details	Basis of authority (e.g. parent of a child under 16 years of age)		

MT EDEN VILLAGE DOCTORS **New Patient Medical Questionnaire**

Please complete one form for each member of your family and hand back to reception

Name:_____ **DOB:** __ / __ / ____

1. 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 <60yr >60yr	☐ Yes	☐ Yes	Migraine	☐ Yes	☐ Yes
Asthma	☐ Yes	☐ Yes	Epilepsy	☐ Yes	☐ Yes
Other lung or respiratory disease or problems	☐ Yes	☐ Yes	Breast cancer	☐ Yes	☐ Yes
Kidney disease or problems	☐ 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

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

3. Please list any **regular medications** that you take

4. Have you had any **operations?** ☐ Yes ☐ No *If yes, please list*

5. Are you **allergic** to any medications? ☐ Yes ☐ No *If yes, please list*

6. Do you **smoke?** ☐ No ☐ Yes If yes, how many / day _____

If Yes - would you like help to quit smoking ☐ Yes ☐ No

Have you ever smoked ☐ No ☐ Yes If yes, how much and for how long _____

when did you give up_____

7. Do you drink **alcohol?** ☐ No ☐ Yes If yes, on average , how much / week _____

and what type_____

8. Do you have any **substance abuse** problems? ☐ Yes ☐ No

9. Women: (*those over 20 years & sexually active*)

When was your most recent cervical smear? _____

Have you ever had an abnormal smear? ☐ Yes ☐ No ☐ Don't know

Have you had a mammogram (*those over 40 years*)? ☐ No ☐ Yes If Yes, when?_____

10. When was your last **Tetanus booster?** _____

11. Are your **childhood immunisations** up to date? ☐ Yes ☐ No ☐ Don't know

Signed:_____ **Date:**_____

If you enrolled and requested your medical notes to be transferred from your previous GP we wish to advise you that we will hold these securely for reference only. The notes will not be specifically reviewed unless you request us to, or unless the Doctor feels that your medical history warrants this. Please be careful to disclose all important medical/surgical/psychiatric information.