|  |  |  |
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| **Fields shaded in blue are compulsory** | Dr Suzanne Washington NZMC 25348 Dr Peter Thomas NZMC 17102  Dr Sue Boswell NZMC 16475 Kate Larkin NZMC 49170 | **NHI** (*Office use only)* |

|  |  |  |  |
| --- | --- | --- | --- |
| **Title** | Given Name | Other Given Name(s) | Family Name |
| **Other Name(s)**  (e.g. maiden name) | | **Occupation and Employer** | |
| **Birth Details** | Day / Month / Year of Birth | Place of Birth | Country of birth |
| **Gender** |   Male Female Gender Diverse (preferred pronoun) | | Marital Status |

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| --- | --- | --- | --- |
| **Contact Details** | Main phone number | Alternative Phone Number | Email address |
| **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 |
| **Emergency Contact** |  |  |  |
| Name | Relationship | Mobile (or other) Phone |

## Authority to Transfer Records

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| **Transfer of Records** | *In order to get the best care possible, I agree to Hauora Health Centre obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register, as I am only able to be enrolled at one practice at a time in New Zealand.* | | |
| Yes, please request transfer of my records | No transfer | Not applicable |
|  |  | |
| Previous Doctor and/or Practice Name | Address / Location | |

|  |  |  |
| --- | --- | --- |
| **NAME** | **Signature** | **Date** |

*Continued on next page*

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| --- | --- | --- | --- |
| **Ethnicity Details**  Which ethnic group(s) do you belong to?  *Tick the space or spaces which apply to you* | **New Zealand European**  **Māori** (list Iwi)  **Pacific Islands (***Please specify country***)**  **European (***Please specify country)*  **Chinese**  **Other Asian** *(Please specify country)*  **British (Please select country)**  England Wales  Scotland Northern Ireland  **Australian**  **American (North or South/Latin)**  **Indian**  **African** *(Please specify country)*  **Other** *(Please specify)* | Do you have a **Community Services Card?**  **You won’t need to provide ID proof** | Yes No |
| Do you have a **High User Health Card?** | Yes No |
| **What is your current smoking status?**  Never smoked  Ex-smoker (less than 12 months)  Current smoker  Ex-smoker (more than 12 months)  **If you currently smoke would you like help to quit?**  Yes No | |
| **Preferred Pharmacy**  Which pharmacy do you regularly collect your prescriptions from? | |
| **MyIndici Patient Portal**  Our patient portal is called “MyIndici” and you can use it to   * Book appointments * View test results * Message your GP securely * View reminders such as when vaccines are due * See your account and pay bills   **Would you like access to our patient portal?** Yes No | |

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| --- | --- | --- | --- |
| **Names of children**  **under 16 to be enrolled** | **Name** | **Gender** | **DOB** |
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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:

|  |  |  |
| --- | --- | --- |
| 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 current work visa/permit and can show that I am legally 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 ongoing provider of general practice health care services.

**I understand** that by enrolling with this practice I will be included in the enrolled population of this practice’s Primary Health Organisation (PHO), Nelson Bays Primary Health, 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.

**PRIVACY STATEMENT. Your health Privacy: We collect your health information to provide a record of care and quality treatment when you need it. Your privacy and the confidentiality of information is very important to us. Your health information will be shared with other health professionals (e.g., Hospital or District Nursing etc.) to provide continuity of care. You do not have to consent to this information being shared, but withholding it may affect the quality of care you receive. You have the right to know where your information is kept, who has access rights and if the system logs users and who has viewed or updated your information. You also have the right to know if your data privacy has been breached and your data has fallen into any unauthorised user’s hands. For more information, please see the accompanying *Use and Confidentiality of your Health Information* fact sheet**

**I understand** that 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.

**I agree** to have my cell phone and/or email address used by Practice staff to send me notifications, test results, recalls and screening. I do not agree to this information being passed on to anyone else outside the health sector without my permission.

**I agree** to be contacted by the Practice staff regarding recalls for health screening such as cervical screening, breast screening and smoking. **I agree** to be automatically opted on to cervical screening and breast screening. I know can opt out at any time.

|  |  |  |  |  |
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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.***

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

*Continued on next page*

The following information is collected to ensure your health records at this practice are correct.

It may also be used to enrol you in health screening or education programmes.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** |  | | | | | **D.O.B** |  | |
| **MEDICAL HISTORY** | | | | | | | | |
| **Please list any allergies you have** | |  | | | | | | |
| **What regular medications do you take?** (include herbal /over the counter medications) | |  | | | | | | |
| **Personal health history** | |  | | | | | | |
| **Last tetanus vaccination** | |  | | | **Other vaccines** | | |  |
| **Alcohol** (number of standard drinks /week): | | | | | | | | |
| **Smoking/Vaping:** If you currently smoke would you like help to quit? Yes. No. | | | | | | | | |
| **Breast Screen Aotearoa (Female Only):**  Do you consent to being on the National Breast screening register? Yes. No. | | | | | | | | |
| **Last cervical smear** | |  | | | **Last mammogram** | | |  |
| **SIGNIFICANT FAMILY HISTORY** | | | | | | | | |
| **Condition** | | | **Yes /No** | **Relationship to you** | | | | |
| Heart disease | | |  |  | | | | |
| Stroke | | |  |  | | | | |
| Cancer | | |  |  | | | | |
| Diabetes | | |  |  | | | | |
| Hepatitis | | |  |  | | | | |

If this form relates to a child, please bring their immunisation record on first visit.

**These are our terms of trade:**

**Financial**

* Payment in full for all appointments is required on the day of your consultation unless a prior arrangement has been made with the Practice Manager.
* Any invoices issued after a consultation are to be paid within 7 days of being issued. A $5 administrative fee is added to invoices not paid within 30 days from date of appointment.
* Charges may be made for telephone consultations, forms left for completion and any other work completed by our doctors outside of consultation time.
* If you wish to cancel your appointment, please try to inform us at least 24 hours in advance. If we don’t hear from you and you don’t attend your appointment then a fee of $20 will be charged.
* Until proof of eligibility is provided you will be charged as per our visitor patient fees schedule. A copy of this is on display in our reception and on our website, [www.hauorahealth.nz](http://www.hauorahealth.nz/)
* Payment for services can be made in person or online. Payment details are provided on our invoices and account statements.
* If you fail to make payments on your account, it may be given to a debt collection agency and you will be liable for any additional debt collection costs incurred.
* If a credit limit or time for payment has been exceeded, you will be notified, and we may decide to no longer provide medical services to you, unless it is an emergency as determined by one of our medical team.

**Behavioural**

As a condition of the practice agreeing to continue my treatment, I promise that I will not whilst I am in the clinic: • swear at staff or in the presence of other patients

• shout or make offensive remarks

• make verbal or physical threats

• attend when intoxicated with alcohol and/or drugs

• damage or steal property

• act in a manner that is likely to cause harassment, alarm, or distress to others in the general

practice

If I breach this agreement, I understand that:

• I may be asked to leave the practice

• police attendance may be requested by practice staff, and

• my future attendance at this practice may be discontinued and I may have to seek health

care elsewhere.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Acknowledge that I have read and agree to the above terms of trade.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_