

# PRACTICE ENROLMENT FORM

**Practice Name** **Botany Town Centre Medical Practice** **Phone Number** (09) 273 6003  
**Address** 588 Chapel Road, Botany Downs 2016 **Fax Number** (09) 273 6004  
 PO Box 64060, Botany Downs 2163  
**GP Provider** **Dr Pieter Vosloo** **NZMC NO** 20138 **EDI Number** tirakau

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

<b>Name</b>	Title	* Given Name	* Other Given Name(s)	* Family Name
<b>Other Name(s)</b> <small>(eg. maiden name) Please tick the name you prefer to be known as</small>				
<b>Birth Details</b>		* Day / Month / Year of Birth	* Place of Birth	* Country of birth
<b>Gender</b>		* <input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender Diverse (please state)
				Occupation

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

<b>Contact Details</b>	Mobile Phone	Home Phone	Email Address
<b>Emergency Contact</b>	Name	Relationship	Mobile (or other) Phone

<b>Transfer of Records</b>	<i>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.</i>		
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor and/or Practice Name		Address / Location

<b>Ethnicity Details</b> <small>Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i></small>	* <input type="radio"/> New Zealand European	<b>Community Services Card</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="radio"/> Maori	Day / Month / Year of Expiry	Card Number			
	<input type="radio"/> Samoan	<b>High User Health Card</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="radio"/> Cook Island Maori	Day / Month / Year of Expiry	Card Number			
	<input type="radio"/> Tongan	<b>Do you Smoke?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No (ex-smoker)	<input type="checkbox"/> Never
	<input type="radio"/> Niuean	Comments:				

\* My declaration of entitlement and eligibility \*

<p><b>I am entitled to enrol because I am <u>residing permanently</u> in New Zealand.</b>  <b><i>The definition of <u>residing permanently</u> in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months</i></b></p>	<input type="checkbox"/>
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**AND THEREFORE I am eligible to enrol because:**

a	I am a New Zealand citizen <i>(If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below)</i>	<input type="checkbox"/>
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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)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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 <b>OR</b> in the control of the Chief Executive of the Ministry of Social Development	<input type="checkbox"/>
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)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>

I confirm that, if requested, I can provide proof of my eligibility	<input type="checkbox"/>	Evidence sighted <i>(Office use only)</i>
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<h2 style="margin: 0;">My agreement to the enrolment process</h2> <p style="margin: 0;"><b>NB. Parent or Caregiver to sign if you are under 16 years</b></p>
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**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. (ProCare Health Ltd. Level 2, 110 Stanley Street, Grafton Ph.09-3777827 [www.procare.co.nz](http://www.procare.co.nz))

**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.

<b>Signatory Details</b>	* Signature	* Day / Month / Year	<input type="checkbox"/> Self-Signing	<input type="checkbox"/> Authority
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**An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.**

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

# 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	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Blood clot	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Heart disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Heart Attack <60yr >60yr	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Migraine	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Other lung or respiratory disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Breast cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Kidney disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Other cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Liver disease of Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Bowel disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Joint disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Tuberculosis (TB)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Depression and/or anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Other mental health illnesses	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> 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: \_\_\_\_\_