National Hauora Coalition

Waihi Health Centre

ENROLMENT FORM

Phone: 07 863 8195 **Address**: 1 Mueller St, Waihi
Email: reception@waihidocs.co.nz **GP2GP**: waihihct
Website:www.waihihealthcentre.co.nz

My preferred GP is:
☐ **Dr Melissa Negretti** #66400 ☐ ~~**Dr Sandie Moss** #12988~~
☐ ~~**Dr Suzanne Greaves** #44123~~ ☐ **Dr Niels Vranks # 86133**

Name	**Title**	**First Name**	**Middle Name**		**Family Name**
Other Name(s)	*eg. Maiden Name / Preferred Name*		**Gender** ☐ **Male**	☐ **Female**	☐ **Gender Diverse (please specify)**
Birth Details	**Date / Month / Year**		**Place of Birth**		**Country of Birth**
Usual Residential Address	**House No. & Street Address**		**Suburb / Rural Location**		**Town / City & Post Code**
Postal Address *If different from above*	**House No. & Street Address or PO Box Number**		**Suburb / Rural Location**		**Town / City & Post Code**
Contact Details	**Home Phone**	**Mobile Phone**	**I consent to receiving Txt Messages** Yes ☐ No ☐		
Emergency Contact/s	Name		Relationship to you		Mobile (or other) Phone
	Name		Relationship to you		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

Ethnicity Details

Which ethnic group(s) do you belong to? Tick the all that apply to you

- ☐ New Zealand European
- ☐ Maori
- ☐ Samoan
- ☐ Cook Island Maori
- ☐ Tongan
- ☐ Chinese
- ☐ Indian
- ☐ Other – Please Specify

Smoking Status Smoker ☐ Never Smoked ☐ Ex-Smoker ☐ No. years since quit

Patient Portal – MANAGE MY HEALTH
I would like to sign up to Manage My Health. I have provided my own individual email address **YES/NO**
I consent to receiving Emails
Yes ☐ No ☐

My INDIVIDUAL Email Address:

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 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**, I decline to have my records transferred
☐ **Not applicable**

Previous Practice Name and Location

Previous Practice Email

FOR OFFICE USE ONLY **NHI NO:** **ENTERED/COMPLETED BY:** (staff initials)

Photo I.D. sighted & copied ☐ Address Verified ☐ NES Enrolment ☐ Transfer of Records Requested ☐

Waihi Health Centre

New Patient Questionnaire

Full Name: _____ D/O/B: ____/____/____

Do you have ANY of the following?

Allergies	**YES / NO**	**If YES, Please list -** _____
High Blood Pressure	**YES / NO**	
Heart Problems	**YES / NO**	
Stroke / TIA	**YES / NO**	
Lung Disease	**YES / NO**	
Kidney Disease	**YES / NO**	
Epilepsy	**YES / NO**	
High Cholesterol	**YES / NO**	
Hepatitis	**YES / NO**	
Cancer	**YES / NO**	
Asthma	**YES / NO**	**If YES, Are you using inhalers? YES / NO**
Diabetes	**YES / NO**	
If YES, *(please circle one)*		**On Insulin / Taking Tablets / Diet Controlled / None**

Alcohol Intake

Do you drink alcohol? **YES / NO**

If YES, What is your average intake?

☐ 1-5 units per week ☐6-10 units per week ☐11-15 units per week ☐15 or more units per week

Medications

Please list ALL Medications you are CURRENTLY taking:

_____

_____

_____

Medical History

Have you had any operations? **YES / NO** **If YES, Please list – What, Where & When**

_____

_____

If you suffer from any other conditions not already listed or you have cultural or spiritual needs that you feel your doctor needs to know about, please comment:

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 current work visa/permit and can show that I am legally able to be in New Zealand for at least 2 years (previous visas/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 this practice's Primary Health Organisation (PHO) Hauraki Primary Health Organisation (HPHO) 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 understand 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**	**Date**	☐ **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)		