Flagstaff Medical Centre

ENROLMENT FORM

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

Legal Name	Title	* Given Name	*Other Given Name	* Family Name
Other Name(s) (eg. maiden name)			**Preferred Name(s)**	
Birth Details		* Day / Month / Year	* Place of Birth	* Country of birth
Sex (at birth)		* ☐ Male ☐ Female	**Gender** you would like to be identified as ☐ Male ☐ Female ☐ Gender Diverse (please state)	
Occupation				

Usual Residential Address	* House (or RAPID) Number & St	* Suburb/Rural Location	* Town / City & Postcode
Postal Address (if different from above)	House Number & St Name or PO Box	Suburb/Rural Delivery	Town / City & Postcode

Contact Details	Work Phone	Mobile Phone	Home Phone	Email Address
Emergency Contact/NOK	Name	Relationship		Mobile (or other) Phone

Community Services Card	☐ Yes	☐ No	Expiry Day / Month / Year	Card Number
High User Health Card	☐ Yes	☐ No	Expiry Day / Month / Year	Card Number

*** Ethnicity Details**

Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you

- ☐ 11 **New Zealand European**
- ☐ 21 **Maori**
  Iwi _____
- ☐ 31 **Samoan**
- ☐ 32 **Cook Island Maori**
- ☐ 33 **Tongan**
- ☐ 34 **Niuean**
- ☐ 42 **Chinese**
- ☐ 43 **Indian**
- ☐ **Other** (such as Dutch, Japanese, Tokelauan)

Please state

Smoking is an important factor influencing health If you are aged 15 and over please tick the space that applies for you

- ☐ Currently smoke
- ☐ Recently quit
- ☐ Ex-smoker (over 1 year)
- ☐ Never smoked

Smoking is hugely negative on your good health. In most cases, you will experience the benefits of quitting immediately.

If you currently smoke, would you like some help to quit?

☐ Yes ☐ No

* 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 Flagstaff Medical Centre I will be included in the enrolled population of Midlands Regional Health Network Charitable Trust 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**
	Basis of authority (e.g. parent of a child under 16 years of age)		

Flagstaff Medical Centre
Screening Information:

Full Name: Mr / Mrs / Ms / Miss

_____

Date of Birth: _____ Ethnicity: _____

Country of Birth:_____

Address: _____Contact Number_____

POA (Power of Attorney for Health)_____Contact Number_____

Next of Kin: _____(Relationship)_____Contact Number_____

Circle appropriate:

Have you ever smoked? Yes / No
Are you a smoker? Yes / No

Do you consume alcohol? Yes / No

Less than 1 pack/day	[ ]	Less than 1 glass/daily	[ ]
1-2 packs/day	[ ]	2-5 glasses/daily	[ ]
More than 2 packs/day	[ ]	More than 6 glasses/daily	[ ]

Have you ever had:		Specify type and Year of Onset/Diagnosis
High blood pressure	[ ]	_____
Operations	[ ]	_____
Asthma	[ ]	_____
Cancer	[ ]	_____
Diabetes	[ ]	_____
Allergies	[ ]	_____

Other ongoing illness: _____

Regular Medications: _____

Has anyone in your family had: eg mother, father, brother, sister etc

High blood pressure	[ ]	Stroke	[ ]
Heart problems (over 60 years)	[ ]	Cancer	[ ]
Heart problems (under 60 years)	[ ]	Diabetes	[ ]

Other ongoing illness_____

Screening:

Date of last smear_____ Date of last mammogram_____

Any abnormal results: Yes / No If yes please specify: _____

How did you hear about us? _____

Would you like to become a registered patient of this practice? Yes / No