Thank you for your enquiry regarding enrolling with Balmoral Doctors

The team at Balmoral Doctors are committed to providing quality care to all of our patients in a warm, friendly and comfortable environment. Our Doctors are fully trained in General Practice and Family Medicine. We believe in supporting you in managing your health within a caring and trusting relationship. We will ensure that that your health information is only seen by people who are involved in your care.

How do I enrol?

To enrol you need to first complete the attached enrolment form. Parents may enrol children under the age of 16 years but children over this age must sign the form themselves. Please note that in all circumstances a NZ Birth Certificate or passport must be provided showing resident / working visas & citizenship. Supporting letters from NZ Ministry of Immigration should also be provided if applicable. If documents are emailed then please ensure forms are clear & legible.

How do I know if I am eligible for publicly funded health & disability services?

Speak to the practice staff or visit the Ministry of Health website & work through the Guide to Eligibility Criteria.

http://www.moh.govt.nz/moh.nsf/indexmh/eligibility-direction

Fee structure

Initial New Patient visit is $85.00. This is for patients 14 years & older with no Community service Card.

$50 for Community Card holders

This is based on a double consultation with the doctor ensuring ample time for discussion & review. After the first visit the fees revert to our standard enrolled rate. Children have a standard single appointment

Contact us

Email: reception@balmoraldoctors.co.nz

Website: www.balmoraldoctors.co.nz

Phone 09 6303518 Address: 502 Dominion, Mt Eden, Auckland

BALMORAL DOCTORS

Balmoral Doctors
502 Dominion Road
Mt Eden
Auckland 1024
Phone 09 630 3518
EDI: adbrfrki

Dr Heather King	12640
Dr Paula West	32998
Dr Ishaan Castelino	75665
Dr Pulasthi Mithraratne	64597
Dr Kristina Panzic	62113
Dr Yoon Hong	75702

Name	(Title)	Given Name	Other Given Name(s)	Family Name	NHI:
Other Name(s) (e.g. 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		

		Do you agree to receive text messages?	☐ Yes	☐ No
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	Do you have Southern Cross Insurance? Policy No _____	☐ Yes	☐ No
		Preferred GP		
		Do you Smoke?	☐ Yes	☐ No (ex-smoker) Cease date: ☐ Never
		We recommend you stop smoking. Would you like support?	☐ Yes	
		This practice promotes good health and we send appropriate advice about screening through our Practice Recall system. Do you consent to receiving this information? ☐ 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 <u>not</u> 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	☐

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 with the Primary Health Organisation (PHO) 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
	Basis of authority (e.g. parent of a child under 16 years of age)		

PATIENT MEDICAL INFORMATION FORM

Diabetes	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No
Heart disease or problems	☐ Yes ☐ No
High cholesterol	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Other lung or respiratory disease or problems	☐ Yes ☐ No
Kidney disease or problems	☐ Yes ☐ No
Liver disease or problems	☐ Yes ☐ No
Bowel disease or problems	☐ Yes ☐ No
Joint disease or problems, arthritis	☐ Yes ☐ No
Depression and/or anxiety	☐ Yes ☐ No
Other mental health Illness	☐ Yes ☐ No

FAMILY HISTORY

Are there any illnesses in your family?	☐ Yes ☐ No
Breast cancer	☐ Yes ☐ No
Bowel cancer	☐ Yes ☐ No
Prostate cancer	☐ Yes ☐ No
Melanoma	☐ Yes ☐ No
Other? See list above and please state.	

MEDICATIONS

Please list any Medication you take
Are you allergic to any medications? ☐ Yes ☐ No

MEDICAL

Have you had any operations	☐ Yes ☐ No
Please list	
Do you drink alcohol? ☐ Yes ☐ No	**How many drinks a week?**
WOMEN PATIENTS	
Date of last Mammogram	
Date of last Smear	

Signed:_____ Print Name:_____ Date_____