ENROLMENT FORM

Blenheim Medical

Dr M Maleki **NZMC: 67384**	**Practice: BLENHEIM MEDICAL** **Address: 47 Scott Street, Blenheim 7201** **Tel: (03) 777 1700** **Email: reception@blenheimmedical.co.nz** **EDI: BLENMMED**	NHI *(Office use only)*

Name	(Title)	Given Name	Other Given Name(s)	Family Name
Other Name(s) (e.g. maiden name)				
Birth Details		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender		☐ Male ☐ Female	☐ Gender diverse (please state)	

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/NOK	Name	Relationship	Mobile (or other) Phone

Ethnicity Details
Which ethnic group(s) do you belong to?

- ◯ New Zealand European
- ◯ Maori
- ◯ Samoan
- ◯ Cook Island Maori
- ◯ Tongan
- ◯ Niuean
- ◯ Chinese
- ◯ Indian
- ◯ Other (Please State)

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.

Transfer of Records ☐ Yes ☐ No ☐ Not Applicable

Previous Doctor & Practice Name

Telephone/Fax Number

Community Services Card	☐ Yes ☐ No	Card Number	Expiry Date
High User Health Card	☐ Yes ☐ No	Card Number	Expiry Date

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 Blenheim Medical I will be included in the enrolled population of Nelson & Marlborough PHO, 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)		

Blenheim Medical - Patient Health Questionnaire

This questionnaire is to help us obtain accurate information for the purpose of health screening and to help us identify issues you may wish to address. Please respond to all questions that apply to you. If you feel uncomfortable about answering any of the questions, or prefer to discuss with your GP or a Nurse, please note this on the form. The information you give us will be used in strict confidence:

First name: **Surname:**
Date of Birth: **Occupation:**
Social profile: **Single/Married/De-facto/Divorced/Widowed**
Ages of children:

Your Past Medical History and Current Medical Problems		
Tick	**Medical conditions**	**Year of onset**
	Diabetes / Pre – Diabetes	
	Heart Attack / Myocardial Infarction	
	Angina	
	Atrial Fibrillation (irregular heart rate)	
	Stroke / TIA	
	DVT (blood clot in legs) / P.E. (blood clot in lungs)	
	High Cholesterol	
	High Blood Pressure / Hypertension	
	Kidney Disease	
	Depression/ Anxiety	
	Other Mental Health Illness	
	Asthma	
	Chronic Lung Disease / Emphysema / Chronic Bronchitis	
	Glaucoma/eye issues	
	Cancer – Type:	
	Arthritis – Osteo /Rheumatoid?	
	Skin cancer – Type:	
	Hepatitis – Type:	
	Sensory Impairment e.g. Sight / Hearing	
	Other important medical conditions not listed above please list below:	

Past Operations:	**Year**

Family History: for example cancer, heart problems, diabetes			
Condition	**Details**	**Age of Onset**	**Relationship to you**

Vaccinations: Please provide dates of vaccines given if known.
Adults – for example - tetanus, Flu vaccine, Shingles Vaccine.
Children – copy of Well-Child booklet Immunisation or overseas history provided: YES/NO Your child may require a 'catchup' vaccination schedule to be arranged if different to the current NZ schedule.

Women:
Cervical Screening
When was your last Cervical Smear? Approx. date and result:
Have you had any abnormal smear results?
Mammograms
When was your last Mammogram? Approx. date and outcome:
Do you have a history of abnormal mammograms or family history breast abnormalities?
Men:
Have you had a prostate check done previously? Blood test/rectal examination (please circle which)
Date:

Regular Medication: *Please bring a print out from a pharmacy if possible.*		
Allergies *To medication / insects/ food /skin products/ plasters*		**Reaction**

Other relevant medical information or other medical problems not covered

Smoking Status information: (15yr and older)			
Have you ever smoked?	Yes / No		
Are you a current smoker?	Yes / No	Can we help you with this?	Yes / No
Are you an Ex- smoker?	Yes/ No	When did you Quit?	Date
Alcohol: Do you drink alcohol? Yes/ No			
How many units?	1-3 units a week	4-7 units a week	7+ units a week
Exercise/Time spent daily:	Light = 0-30 mins daily	Moderate =30mins - 1 hour daily	Intense = 1hr + daily
What exercise do you do? *For example- walking/cycling/swimming/gym etc.*			

Thank you for taking the time to fill out this form. We look forward to meeting you and working in partnership with you to manage your health.