MORROW STREET CLINIC	**ENROLMENT FORM**	**Morrow Street Clinic** 277 Broadway, Newmarket Auckland, New Zealand 1023 **Ph:** (09) 242 1288 **EDI**: kptmostc **Email:** info@morrowstreetclinic.co.nz	ProCARE

Fields shaded are compulsory	Practice Specific Field	**NHI** ***(Office use only)***

Name	**(Title)**	**Given Name**	**Other Given Name(s)**	**Family Name**
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 Your Medical 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. Please tick option that you prefer:

SIGNATURE:

☐ **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 [Iwi: _____]
- ○ Samoan
- ○ Cook Island Maori
- ○ Tongan
- ○ Niuean
- ○ Chinese
- ○ Indian
- ○ Other (such as Dutch, Japanese, Tokelauan). Please state

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 _____

Do you Smoke?	☐ Yes	☐ No (ex-smoker)	☐ Never

		Practice Specific Field

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 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 *(Patient's)*	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)		

MORROW STREET CLINIC – NEW PATIENT MEDICAL QUESTIONNAIRE

Please complete one form for **each member** of your family and hand back to reception.

Name:_____ **DOB:** ___/___/___

Do you have any, or have had any of the following medical problems? Or is there a family history of the following:

Medical Condition	Self	Family	Medical Condition	Self	Family
Diabetes	☐ Yes	☐ Yes	Blood clot	☐ Yes	☐ Yes
High blood pressure	☐ Yes	☐ Yes	Stroke	☐ Yes	☐ Yes
Heart disease or problems	☐ Yes	☐ Yes	High cholesterol	☐ Yes	☐ Yes
Heart Attack <60yr >60yr	☐ Yes	☐ Yes	Migraine	☐ Yes	☐ Yes
Asthma	☐ Yes	☐ Yes	Epilepsy	☐ Yes	☐ Yes
Other lung or respiratory disease or problems	☐ Yes	☐ Yes	Breast cancer	☐ Yes	☐ Yes
Kidney disease or problems	☐ Yes	☐ Yes	Other cancer	☐ Yes	☐ Yes
Liver disease or Hepatitis	☐ Yes	☐ Yes	Glaucoma	☐ Yes	☐ Yes
Bowel disease or problems	☐ Yes	☐ Yes	Rheumatic Fever	☐ Yes	☐ Yes
Joint disease or problems, arthritis	☐ Yes	☐ Yes	Tuberculosis (TB)	☐ Yes	☐ Yes
Depression and/or anxiety	☐ Yes	☐ Yes	Eczema	☐ Yes	☐ Yes
Other mental health illnesses	☐ Yes	☐ Yes	Hay Fever	☐ Yes	☐ Yes

1. Do you have any other **health, disability problems or inherited conditions**? – *please list*

_____

2. Please list any **regular medications** that you take:

_____

3. Have you had any **operations?** ☐ Yes ☐ No *If **yes**, please list*

_____

4. Are you **allergic** to any medications? ☐ Yes ☐ No *If **yes**, please list*

_____

5. Do you **smoke?** ☐ No ☐ Yes how many / day _____
If Yes - would you like help to **quit smoking?** ☐ Yes ☐ No

If yes, how much and for how long? _____ When did you give up _____

6. Do you drink **alcohol?** ☐ No ☐ Yes If yes, on average, how much / week? _____ and what type? _____

7. Do you have any **substance abuse** problems? ☐ No ☐ Yes

8. When was your last Tetanus booster? _____

9. Are your childhood immunisations up to date? ☐ Yes ☐ No ☐ Don't know

Women: (*those over 20 years & sexually active)*

10. When was your most recent cervical smear? _____

11. Have you ever had an abnormal smear? ☐ Yes ☐ No ☐ Don't know

12. Have you had a mammogram (*those over 40 years*)? ☐ No ☐ Yes If Yes, when? _____

Patient Signed:_____ **Date:** _____