Cromwell Medical Centre
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NEW PATIENT ENROLMENT FORM

Title	Mr Mrs Ms Miss Dr	**First Name(s)**		**NHI**	
				Family Name	
Occupation				**Other Names Known By** (e.g. maiden name)	
Gender	☐ **Male** ☐ **Female**			**Place / country of birth**	
Physical Address	Street or Rapid (rural) number	Name of Street		**Date of Birth**	______ / ______ / ______ Day Month Year
Note that we need Rapid Numbers and Road Address. R D not sufficient.	Suburb City/Town Postcode			**Community Services Card**	**YES / NO** **Card No:** ____________ **Expiry Date:** ____________
Postal Address				**High User Health Card**	**YES / NO** **Card No:** ____________ **Expiry Date:** ____________
Contact	**Day Phone:**			**Cell Phone:**	
Details	**Night Phone:**			**Email:**	
Emergency	**Name of Person:**			**Relationship to you:**	
Contact	**Day Phone:**			**Cell Phone:**	

Which ethnic group do you belong to? Mark the space or spaces which apply to you	
New Zealand European	
Māori	
Samoan	
Cook Islands Maori	
Tongan	
Niuean	
Chinese	
Indian	
Dutch	
Other such as JAPANESE, TOKELAUAN etc Please state:	

Please circle your smoking status:	Never Smoked Smoker Trying to give up Ex-Smoker Quit date:

Is there any other information that you would like us to know?

Transfer of Records

In order to get the best care possible, I agree to Cromwell Medical Centre obtaining my records from my previous Doctor. I also understand that I will be removed from their Practice register:

Yes ☐ No ☐ Not applicable ☐

Doctor's Name:

Address / Location:

Enrolment in the Practice / Primary Health Organisation (PHO)

I intend to use <u>CROMWELL MEDICAL CENTRE</u> as my regular and ongoing provider of general practice/ GP/ First Level primary health care services.

I am entitled to enrol because I am residing permanently in New Zealand[1] and meet one of the following eligibility criteria:

a)	I am a New Zealand citizen **OR**	Yes / No
b)	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	Yes / No
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	Yes / No
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)	Yes / No
e)	I am an interim visa holder who was eligible immediately before my interim visa started	Yes / No
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	Yes / No
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	Yes / No
h)	I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder	Yes / No
i)	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)	Yes / No
j)	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	Yes / No
k)	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund.	Yes / No

I confirm that, if requested, I can provide proof of my eligibility.

My agreement to the enrolment process

I choose to enrol with this practice as my regular and on-going provider of general practice / GP / First Level primary health care services.

I understand that by enrolling with this practice I will be enrolled with the Primary Health Organisation (PHO) this practice belongs to, and my name address and other identification details will be included on both the Practice and the PHO Enrolment Register.

I understand that if I visit another 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 with the PHO, and their contact details.

I have read and I agree with the Health Information Privacy Statement (Page 4 of Enrolment Form).

I agree to inform the practice of any changes in my eligibility.

SIGNATURE:	**DATE** / /

***OR** Parent or caregiver to sign if you are under 16 years*

Signed by <u>AUTHORITY[2]</u>:	**DATE:** / /
Full Name of Authority:	
Relationship:	**Contact Phone Number:**
Address:	

[1] The definition residing in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months.

[2] An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

MEDICAL HISTORY DETAILS

FAMILY NAME:			MALE / FEMALE
GIVEN NAMES:			Mr Mrs Ms Miss Dr
DOB:	ETHNICITY:		DR:
ADDRESS:			

EMPLOYMENT DETAILS:	
CURRENT EMPLOYER:	OCCUPATION:
ADDRESS:	PHONE NO:

SMOKING STATUS: If you do smoke, do you wish to have smoking cessation advice? Please circle: YES / NO

How many cigarettes do you smoke a day (please tick)

Never Smoked ☐	Ex Smoker ☐	Finish Date
1 – 9 per day ☐	10 – 20 per day ☐	1 – 2 Smokes ☐

ALCOHOL CONSUMPTION:

How many alcoholic drinks do you drink per day (please tick)

Non Drinker ☐	Less than one Drink ☐	1 – 2 Drinks ☐
3 – 6 Drinks ☐	7 or more Drinks ☐	Other

CURRENT MEDICAL INFORMATION:

Allergies: Medications and Foods	
Long Term Medications: (include supplements and vitamins)	
Medical Conditions: Asthma / Diabetes etc.	

WOMEN:	Date of last cervical smear:		Date of last mammogram:	

FAMILY HISTORY:

Do you have a family history of diabetes? **YES / NO**	**IF YES What is that person's relationship to you?**		
How is their diabetes managed	Diet ☐	Tablets ☐	Insulin ☐

Any family history of:	*Relationship to You*	*Age of Onset*
High Blood Pressure		
Heart Attacks		
Stroke		
Cancer (state type)		
Other Family Illnesses (please specify)		

HEALTH INFORMATION PRIVACY STATEMENT

I understand the following:

Access to my health information
I have the right to access (and have corrected) my health information under Rules 6 and 7 of the Health Information Privacy Code 1994.

Visiting another GP
If I visit another GP who is not my regular doctor I will be asked for permission to share information from the visit with my regular doctor or practice.

If I have a High User Health Card or Community Services Card and I visit another GP who is not my regular doctor, he/she can make a claim for a subsidy, and the practice I am enrolled in will be informed of the date of that visit. The name of the practice I visited and the reason(s) for the visit will not be disclosed unless I give my consent.

Patient Enrolment Information
The information I have provided on the Practice Enrolment Form will be:

- held by the practice
- used by the Ministry of Health to give me a National Health Index (NHI) number, or update any changes
- sent to the PHO and Ministry of Health to obtain subsidised funding on my behalf
- 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.

Health Information
Members of my health team may:

- add to my health record during any services provided to me and use that information to provide appropriate care
- share relevant health information to other health professionals who are directly involved in my care

Audit
In the case of financial audits, my health information may be reviewed by an auditor for checking a financial claim made by the practice, but only according to the terms and conditions of section 22G of the Health Act (or any subsequent applicable Act). I may be contacted by the auditor to check that services have been received. If the audit involves checking on health matters, an appropriately qualified health care practitioner will view the health records.

Health Programmes
Health data relevant to a programme in which I am enrolled (e.g. Breast Screening, Immunisation, Diabetes) may be sent to the PHO or the external health agency managing this programme.

Other Uses of Health Information
Health information *which will not include my name but may include my National Health Index Identifier (NHI)* may be used by health agencies such as the District Health Board, Ministry of Health or PHO for the following purposes, as long as it is not used or published in a way that can identify me:

- health service planning and reporting
- monitoring service quality
- payment

Research
My health information may be used for health research, but only if this has been approved by an Ethics Committee and will not be used or published in a way that can identify me.

Except as listed above, I understand that details about my health status or the services I have received will remain confidential within the medical practice unless I give specific consent for this information to be communicated.

Enquiries
If you have any concerns about any matter relating to your health information, please contact our Privacy Officer.

Privacy and your health information

Our practice follows the rules set out below whenever we collect, use, store or disclose information about your health.

COLLECTING YOUR HEALTH INFORMATION

When we collect health information from you we will:

- Only collect the information for the purpose of treating you (or for some related purpose)
- Collect the information directly from you unless you have authorised us to collect the information from someone else (or we have some other lawful reason for collecting the information and what we will do with it.
- Tell you why we are collecting the information and what we will do with it.

USING YOUR HEALTH INFORMATION

We will not use your health information for any purpose other than for the purpose of treating you unless we get your consent or we will use your information in a way that doesn't identify you (or where we have some other lawful reason for doing so).

STORING YOUR HEALTH INFORMATION

We will store your health information securely so that only authorised people can access or use your information.

DISLOSING YOUR HEALTH INFORMATION

We will not disclose your health information to anyone without your consent unless we have a lawful reason for doing so.

ACCESS AND CORRECTION OF YOUR HEALTH INFORMATION

- You can ask us to confirm whether we hold information about you. If we hold information about you, you have the right to access the information.
- You can ask us to correct any information that we hold about you if you think that the information is inaccurate. If we refuse to correct your information, you can ask us to put a note on your information that states that you have asked for the correction to be made.

ENQUIRIES

If you have any concerns about any matter relating to your health information, please ask to speak to our privacy officer.

CROMWELL
MEDICAL CENTRE