South Link Health Group	**PATIENT ENROLMENT FORM**	**East Otago Health** **117 District Road,** **PALMERSTON 9430** **Ph 03 465 1444 Fax 03 4651445**
GP2GP: ***Jane Roberts***	**NZMC: 12345 EDI: palmerhc**	***NHI no: ……***

1. PATIENT INFORMATION

FAMILY NAME				**GENDER** ☐ Male ☐ Female ☐ Gender Diverse (please state)……	
Title		**First Name**		Middle Name	
Preferred Name				**OCCUPATION:**	
BIRTH DETAILS:	DOB: Date/Month/Year		Place of Birth		Country of Birth

ETHNICITY Which ethnic group(s) do you belong to? **Tick the boxes which apply to you**

☐	New Zealand European	☐	NZ Maori	Iwi:			
☐	Cook Islands Maori	☐	Samoan	☐	Tongan	☐	Fijian
☐	Niuean	☐	Indian	☐	Chinese	☐	
☐	Other (such as Dutch, Japanese, Tokelauan) Please State:						

Preferred Language		Do you need an interpreter	☐ Yes	☐ No

Community Services Card	Card No:		Expiry Date		Sighted (official use) ☐ Yes ☐ No
High User Health Card	Card No:		Expiry Date		Sighted (official use) ☐ Yes ☐ No

2. CONTACT DETAILS

Residential Address – This MUST be a physical address

House or Rapid Number and Street Name	Suburb/Rural Location	Town/City and Postcode

Postal Address (If different to above physical address)

House No and Street Name or PO Box No	Suburb/Rural Delivery	Town/City and Postcode

PHONE NOS:	Home:	Cell Ph:	Work:
Email:			
Which methods of contact do you prefer	☐ Text	☐ Phone Call	☐ Email

3. EMERGENCY/NEXT OF KIN CONTACTt

Name				Relationship	
Home Phone	( )	Mobile	( )	Work Phone	( )

4. TRANSFER OF RECORDS FROM PREVIOUS PRACTICE **GP2GP preferred**

In order to get the best care possible, I agree to East Otago Health 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/orPractice Name	Address/Location

PATIENT NAME:_____

*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 enroll 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**	☐

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 permanent resident visa (or a residence permit if issued before December 2010	☐
C	I am an Australian citizen or an 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 of the 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 New Zealand and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund.	☐

***I can confirm that, if requested, I can provide proof of my eligibility**	☐	Evidence Sighted: *Office Use Only -*

NB: Proof of eligibility is required for all Visa holders. A copy of your visa and passport must be presented.

MY AGREEMENT TO THE ENROLLMENT PROCESS

NB: Parent of Caregiver must sign if you are under 16 years.

I intend to use East Otago Health as my regular and on-going provider of general practice/GP/First Level primary health care services.

I understand that by enrolling with **East Otago Health** I will be included in the enrolled population of Wellsouth Primary Health Network, 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 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 PHO's name and contact details.

I have read and I agree with the Health Information Privacy 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 if 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 understand that the practice may share my health information between healthcare providers using HealthOne, a secure system for storing electronic patient records and that all information on HealthOne is kept confidential and checks are in place to monitor all access.

I understand that further information on HealthOne is available from the practice on request.

I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

I agree to receiving communication via texts where applicable on my or my guardians cell phone

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Patient Signature / *Authority Signature — Date

(*An Authority is the legal right to sign for another person if for some reason they are unable to sign for themselves)

/ /

Authority Name — Relationship to Patient — Contact Phone — Date

(Only if signed above by Authority)

East Otago Health

MEDICAL INFORMATION

NAME: _____ **Date of Birth:** _____

1. Personal History

Height cm	Weight kg	Waist Circumference cm
Current Medical Problems		
Current Medications - Prescribed		
Current Medications – Over the Counter/Traditional		
Allergies (for medicines) Previous Surgical Procedures		

2. Lifestyle

Smoking Status (Please circle) **Never Smoked** **Ex Smoker** Quit Date:_____

Current Smoker Year Started _____ How many per day? _____

Would you like help to quit? ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No Type of Alcohol? _____ How many alcohol free days per week _____

How much do you drink in a week? _____

Recreational Drugs	☐ Never had one	☐ Yes - Type: _____
Exercise (Days per week)	_____ Days	_____minutes per exercise session

3. Screening and Immunisation

Mammogram (women 45-69 years)	☐ Never had one	☐ Yes - Date / /	
Cervical Smear (women 20-69 years)	☐ Never had one ☐ I have had abnormal smears in the past	☐ Yes - Date of last smear / / ☐ I have had a hysterectomy	
Prostate (men 48 years+)	☐ Yes Date / /	☐ No – Never had one	
Adults - Tetanus -	☐ Yes Year last done _____	☐ No – Never had one	
Children - Childhood Immunisations	☐ Yes - up-to-date	☐ Yes – some but not up-to-date	☐ No – not immunised

4. Past History

☐ Asthma	☐ Bowel Cancer	☐ High Cholesterol	☐ Tuberculosis
☐ Diabetes	☐ High Blood Pressure	☐ Melanoma	☐ Other
☐ Heart Disease	☐ Kidney Disease	☐ Mental Health Problems	
☐ Breast Cancer	☐ Hepatitis	☐ Strokes	

5. Family History

☐ Asthma	☐ Bowel Cancer	☐ High Cholesterol	☐ Tuberculosis
☐ Diabetes	☐ Ovarian Cancer	☐ Melanoma	☐ Glaucoma
☐ Heart Disease	☐ High Blood Pressure	☐ Mental Health Problems	☐ Hepatitis
☐ Breast Cancer	☐ Kidney Disease	☐ Strokes	☐ Other