ENROLMENT FORM

WBOP PHO
Western Bay of Plenty Primary Health Organisation

PAPAMOA BEACH FAMLY PRACTICE		**5 Golden Sands Drive** **Papamoa** **Email – reception@psmc.co.nz**	**Ph 07 5421104** **Fax 07 542 2429**
Provider	**NZMC**	**EDI -** papamoa	**NHI**

Fields above for Office Use ONLY

Legal Name	Title	Surname/Family Name	First/Given Name
	Middle Name(s)	Preferred Name	Maiden Name
Birth Details	Day / Month / Year of Birth	Place of Birth	Country of Birth
Gender	☐ Male ☐ Female ☐ Gender diverse (please state)		Primary Language

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	

Next Of Kin / Emergency Contact	Name	Relationship	Mobile (or other) Phone
	Address		

	Yes	No	Day / Month / Year of Expiry	Card Number (if known)
Community Services Card	☐	☐		
High User Health Card	☐	☐		

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

IWI	*Occupation:*	*Employer:*
	Address:	

Smoking Status (applies to 15 years & over ONLY)

Never smoked ☐ Current smoker ☐

Ex-smoker less than 12 months ☐

Ex-smoker longer than 12 months ☐

Would you like support to quit? Yes ☐ No ☐

Consent to Receive Communications via *Email…Text...Patient Portal* *(if available)*

Please tick applicable boxes to give your consent:

☐ Text Message ☐ Patient Portal (secure)

☐ Email (non-secure)

Transfer of Records Authority	*In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor.* *I understand I will be removed from their practice register, as I am only able to be enrolled at 1 practice at a time in NZ.*	
	☐ Yes - please request transfer of my records ☐ Not Applicable	Previous Doctor and/or Practice Name
	Signature Day / Month / Year	Address / Location

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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 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 I have provided 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 ***(insert practice name)*** I will be included in the enrolled population of **Western Bay of Plenty PHO** and my name, address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers. Personal details and clinical notes may be shared with other Health Providers, or third party requests as part of my healthcare e.g ACC, Insurance Company requests, Ministry of Health, WINZ etc.

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

I agree to the Terms and Conditions of Trade of (Practice Name) and undertake to pay any fees applicable for Practice Services & all costs incurred in collection of any debt for myself & my dependents.

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)		

HEALTH QUESTIONNAIRE

NAME: ________________________________ DOB _____________________________

We would be grateful If you would complete the questionnaire below so we have some information about your past medical history.

Have you ever had a problem with: **(please circle the answer)**

Asthma	yes/no
Diabetes	yes/no
High Blood pressure	yes/no
Heart	yes/no
Epilepsy	yes/no
Cancer	yes/no
Thyroid	yes/no
Hepatitis	yes/no

Do you have a family history of any significant medical conditions i.e. heart problems, cancer, diabetes?

Do you have any allergies? If so, what are you allergic to and what is the reaction?

Have you ever had any operations? If so, please specify:

Do you smoke? -please circle: yes/no

If so, how many per day? _______For how many years? ___________

If you are an ex-smoker, how long ago did you stop?

If you are a current smoker, have you thought about quitting and would you like support to do so?
Please circle: yes, I would like support/ no, I would not like support

Do you drink alcohol? -please circle: yes/no If so, how many units per week? _______

THANK-YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE