



# PATIENT ENROLMENT FORM

East Otago Health  
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PALMERSTON 9430  
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GP2GP: Jane Roberts

NZMC: 12345 EDI: palmerhc

NHI no: .....

## 1. PATIENT INFORMATION

FAMILY NAME				GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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					
<input type="checkbox"/>	New Zealand European	<input type="checkbox"/>	NZ Maori	Iwi:	
<input type="checkbox"/>	Cook Islands Maori	<input type="checkbox"/>	Samoan	<input type="checkbox"/>	Tongan <input type="checkbox"/> Fijian
<input type="checkbox"/>	Niuean	<input type="checkbox"/>	Indian	<input type="checkbox"/>	Chinese <input type="checkbox"/>
<input type="checkbox"/>	Other (such as Dutch, Japanese, Tokelauan) Please State:				
Preferred Language					Do you need an interpreter <input type="checkbox"/> Yes <input type="checkbox"/> No
Community Services Card		Card No:		Expiry Date	Sighted (official use) <input type="checkbox"/> Yes <input type="checkbox"/> No
High User Health Card		Card No:		Expiry Date	Sighted (official use) <input type="checkbox"/> Yes <input type="checkbox"/> No

## 2. CONTACT DETAILS

<b>Residential Address – This MUST be a physical address</b>					
House or Rapid Number and Street Name		Suburb/Rural Location		Town/City and Postcode	
<b>Postal Address (if different to above physical address)</b>					
House No and Street Name or PO Box No		Suburb/Rural Delivery		Town/City and Postcode	
PHONE NOS:	Home:	Cell Ph:		Work:	
<b>Email:</b>					
Which methods of contact do you prefer				<input type="checkbox"/> Text	<input type="checkbox"/> Phone Call <input type="checkbox"/> Email

## 3. EMERGENCY/NEXT OF KIN CONTACT

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.*

<input type="checkbox"/> Yes please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not Applicable
Previous Doctor and/or Practice Name		Address/Location

PATIENT NAME: \_\_\_\_\_

**\*MY DECLARATION OF ENTITLEMENT AND ELIGIBILITY**

<b>* I am entitled to enrol because I am residing permanently in New Zealand</b> <i>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>	<input type="checkbox"/>
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**\* I am eligible to enroll because:**

<b>A</b> 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)	<input type="checkbox"/>
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If you are **not** a New Zealand citizen please tick which eligibility criteria applies to you (B – J) below:

<b>B</b> I hold a resident visa or permanent resident visa (or a residence permit if issued before December 2010)	<input type="checkbox"/>
<b>C</b> 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	<input type="checkbox"/>
<b>D</b> 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)	<input type="checkbox"/>
<b>E</b> I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
<b>F</b> 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	<input type="checkbox"/>
<b>G</b> 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 <b>OR</b> in the control of the Chief Executive of the Ministry of Social Development	<input type="checkbox"/>
<b>H</b> 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)	<input type="checkbox"/>
<b>I</b> I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
<b>J</b> 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.	<input type="checkbox"/>

<b>*I can confirm that, if requested, I can provide proof of my eligibility</b>	<input type="checkbox"/>	Evidence Sighted: <i>Office Use Only</i> -
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**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 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 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

_____ / _____	_____ / _____		
Patient Signature / *Authority Signature <small>(*An Authority is the legal right to sign for another person if for some reason they are unable to sign for themselves)</small>	Date		
_____ / _____	_____ / _____		
Authority Name <small>(Only if signed above by Authority)</small>	Relationship to Patient	Contact Phone	Date

# 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) <b>Never Smoked</b> <span style="margin-left: 150px;"><b>Ex Smoker</b> Quit Date: _____</span>			
<b>Current Smoker</b> Year Started _____ How many per day? _____			
Would you like help to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No Type of Alcohol? _____ How many alcohol free days per week _____			
How much do you drink in a week? _____			
Recreational Drugs	<input type="checkbox"/> Never had one <input type="checkbox"/> Yes - Type: _____		
Exercise (Days per week)	_____ Days _____ minutes per exercise session		
3. Screening and Immunisation			
Mammogram (women 45-69 years)	<input type="checkbox"/> Never had one <input type="checkbox"/> Yes - Date / /		
Cervical Smear (women 20-69 years)	<input type="checkbox"/> Never had one <input type="checkbox"/> Yes - Date of last smear / /		
<input type="checkbox"/> I have had abnormal smears in the past		<input type="checkbox"/> I have had a hysterectomy	
Prostate (men 48 years+)	<input type="checkbox"/> Yes Date / /		<input type="checkbox"/> No – Never had one
Adults - Tetanus -	<input type="checkbox"/> Yes Year last done _____		<input type="checkbox"/> No – Never had one
Children - Childhood Immunisations	<input type="checkbox"/> Yes - up-to-date	<input type="checkbox"/> Yes – some but not up-to-date	<input type="checkbox"/> No – not immunised
4. Past History			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bowel Cancer	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Other
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Mental Health Problems	
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Strokes	
5. Family History			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bowel Cancer	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mental Health Problems	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Strokes	<input type="checkbox"/> Other

