
 <p>TE ATATU SOUTH MEDICAL CENTRE & SKIN CLINIC Promoting Health & Wellness</p>	273, Te Atatu Road, Te Atatu South, Auckland, 0610 Ph: 09 834 66 00 Fax: 09 834 8601 Email: reception@tsmc.co.nz www.tsmc.co.nz GP2GP/EDI: tatatumc	<div style="border: 1px solid black; padding: 5px;"> Dr Kawshi De Silva - 60931 Dr Huma Naveed - 46656 Dr Robert Jing - 71605 </div>	<h1 style="margin: 0;">ENROLMENT FORM</h1> 

Enrolment status (Office use only)		NHI (Office use only)		<i>Please fill in as much details as possible.</i> *Compulsory <i>Attach a copy of your photo ID.</i>	
*Legal Name	Title	Given Name	Other Given Name(s)	Family Name	
*Other Name(s) (ex. maiden name) Please tick the name you prefer to be known as					
*Birth Details		Day/ Month/Year	Place of Birth	Country of birth	
*Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender diverse (please state)			Occupation	
*Usual Residential Address	House (or RAPID) Number and Street Name		Suburb/Rural Location	Town / City & Postcode	
Postal Address (if different from above)	House Number & Street Name or PO Box No.		Suburb/Rural Delivery	Town / City & Postcode	
*Contact Details	Mobile Phone	Home Phone	Email Address		
*Emergency Contact	Name		Relationship	Mobile (or other) Phone	
Community Services Card No.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry		
High User Health Card No.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry		
*Transfer of Records	<i>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 the previous practice register.</i>				
	<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		
*Ethnicity Details Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	<input type="radio"/> New Zealand European <input type="radio"/> Maori <input type="radio"/> Samoan <input type="radio"/> Cook Island Maori <input type="radio"/> Tongan <input type="radio"/> Niuean <input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state		Patient Survey <i>From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.</i>		
			Patient Survey Contact Details: As provided above <input type="checkbox"/>		
			Alternative contact details:		
			I do not wish to participate in the Patient survey <input type="checkbox"/>		

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

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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**)

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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)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>

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	Signature	Day / Month / Year	<input type="checkbox"/> Self-Signing	<input type="checkbox"/> Authority
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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)		

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	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Blood clot	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Heart disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Heart Attack <60yr >60yr	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Migraine	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Other lung or respiratory disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Breast cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Kidney disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Other cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Liver disease or Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Bowel disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Joint disease or problems, arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Tuberculosis (TB)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Depression and/or anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Other mental health illnesses	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 If yes, how many / day

If Yes - would you like help to **quit smoking** ☐ Yes ☐ No

Have you **ever smoked**? ☐ No ☐ Yes 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 immunisation 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?

Signed: _____

Date: