National Hauora Coalition

# PRACTICE ENROLMENT FORM

## Oceania Healthcare Centre

## Awatere

1340 Victoria Street, Beerescourt, Hamilton 3200

*Circle the correct location:* **ILU / CARE**

*Please select Nurse Practitioner:*

- **Bridget Richards- NCNZ#: 160963** ☐
- **Heather Rhodes - NCNZ#: 322327** ☐

EDI: v2nh4vrx - Email: primarycare@oceaniahealthcare.co.nz- Ph: 0800 360 524

| **NHI:** | **Birth Certificate:** | **Passport:** |
|---|---|---|

***ILU: Please provide a copy of your passport, or birth certificate + ID**

***Fields shaded in blue are compulsory**

| **Name** | (Title) | Given Name | Other Given Name(s) | Family Name |
|---|---|---|---|---|
| **Other Name(s)** (eg. maiden name) Please tick the name you prefer to be known as | | | | |
| **Birth Details** | | Day / Month / Year of Birth | Place of Birth | Country of birth |
| **Gender** | | ☐ Male ☐ Female ☐ Gender diverse (please state) | | Occupation |

| **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 |

| **Patient Contact Details** | Mobile Phone | Home Phone | Email Address |
|---|---|---|---|
| **Emergency Contact or EPOA** | Name / email | Relationship | Mobile (or other) Phone |

| **Transfer of Records** | *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 their practice register, as I am only able to be enrolled at one practice at a time in New Zealand.* | | |
|---|---|---|---|
| | ☐ Yes, please request transfer of my records | ☐ No transfer | ☐ Not applicable |
| | Previous Doctor and/or Practice Name | Address / Location | |

**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

| **Community Services Card** | ☐ Yes | ☐ No |
|---|---|---|
| Day / Month / Year of Expiry | Card Number | |
| **High User Health Card** | ☐ Yes | ☐ No |
| Day / Month / Year of Expiry | Card Number | |

Practice Specific Field

# My declaration of entitlement and eligibility

| | |
|---|---|
| **I am entitled to enrol** because I am residing permanently in New Zealand.<br>*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* | ☐ |

**AND 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 **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) | ☐ |
| 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 current work visa/permit and can show that I am legally able to be in New Zealand for at least 2 years (previous visas / 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, 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 ongoing provider of general practice / GP / health care services.

**I understand** that by enrolling with this practice I will be included in the enrolled population of this practice's Primary Health Organisation (PHO) [Western Bay PHO], 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 understand** 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 | ☐ 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**<br>*(where signatory is not the enrolling person)* | Full Name | Relationship | Contact Phone |
| | Legal basis of authority (e.g. parent of a child under 16 years of age) | | |

# Patient Medical Information

| Blood Pressure | Weight | Height | Preferred Pharmacy | |
|---|---|---|---|---|
| | | | Name: | Address: |

| | |
|---|---|
| **Current Medical Conditions** | |
| **Current Medications**<br>* Please provide current prescription or a printout from your pharmacy listing your current medications | |
| **Any allergies?** | |
| **Any medical alerts?** | |
| **Family history of the following diseases:** | ☐ cardiovascular disease<br>☐ vascular disease<br>☐ Diabetes<br>☐ None<br>☐ Unknown |
| **Previous Surgeries:**<br>*Please list any previous surgeries and the approximate year each was performed* | |
| **Previous Procedures:**<br>*(e.g.: colonoscopy, mammogram, cervical smear, etc.) . Please list any previous medical procedures and the approximate year each was performed* | |
| **Previous Immunizations:**<br>*Please list any immunizations received and the approximate year* | |

| | | | |
|---|---|---|---|
| **Smoking Status: (please circle)** | Current Smoker | Ex-Smoker:<br>Less than 12 months ago ☐<br>More than 12 months ago ☐ | Never Smoked |