Central Family Healthcare Ltd
New patient enrolment & questionnaire form

Patient Name ______________________ **DOB** ________

I understand that I will be removed from the register of my previous general practice and I agree to complete the attached form to request the transfer of my medical records (and/or my child/children under 16 years who are in my custody)

Please enrol me (and/or my child/children under 16 years who are in my custody) on your practice register.

By enrolling with Central Family Healthcare Ltd I confirm I understand the following:

- Central Family Healthcare Ltd will become my preferred provider of general practice services.
- While I am enrolled with Central Family Healthcare Ltd, for funding purposes, the Ministry of Health will inform the practice and Manaia PHO of the date/s on which I visit any other general practice.
- Routine practice services include recalls for preventive healthcare but I can request not to be recalled.
- I am also enrolling with Manaia PHO and have been given information on what enrolment means.
- I will be part of Central Family Healthcare Ltd patient population for funding purposes and the Ministry of Health and Manaia PHO may access this register for population health and funding purposes.
- The privacy of my personal and health information will be protected as per the Health Information Privacy Code 1994, and I confirm I have been provided with information on what this means.
- A National Health Index (NHI) number will be attached to my records

MEDICAL QUESTIONAIRE

Please list any current medical conditions or past surgical procedures

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Please list any current medications you take

Do you have any allergies? (please list)

____

Please tick if you have a family history of
Diabeties ___ Asthma ___
Heart Disease ___ (Age & relationship to you when Cardiac Event occurred)______________

Cancer ___ (Age & relationship when relative had cancer) _______________________
Epilepsy ___
Bleeding disorder ___ Hypertension ___

Date of last tetanus ________________

FEMALE Patients
Aged 20-70 yrs date of last smear __________
Aged 45-70 yrs date of last mammogram __________
OR if you DECLINE to have them _________________

SMOKING is an important factor influencing health. Please tick which applies to you. ***For patients aged 15years and over*.**

I have never smoked ____
In the past I have smoked daily for more than a year, but no longer smoke ___
I am currently a smoker ____

ALCOHOL
How many standard drinks per week _____
For patients aged 15 years and over.

Signed	Date