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|  | C:\Users\jfleming\Desktop\CC logo for email.jpg **ENROLMENT FORM**  7 Mansfield Terrace, Regent- Whangarei  **P**: 09 438 2703  **EDI**: cenfamhc  **E: reception@centralfamily.co.nz** |

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| **Provider: GP2GP*: GP names & NZMC #***  **Dr Adrienne Henderson 46920 Dr Kevin Miller 67406 Dr Tim Cunningham 17345 Dr Dirk Ziegert 43548** | NHI *(Office use only)* |

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| --- | --- | --- | --- | --- | --- | --- |
| **Legal Name \*** |  |  | | |  |  |
| (Title) | Given Name | | | Middle Name(s) | Family Name |
| **Other Name(s)**  (eg. maiden name /preferred name) | |  | | |  |  |
| **Birth Details \*** | |  | | |  |  |
| Day / Month / Year of Birth | | | Place of Birth | Country of birth |
| **Gender \*** | |  |  |   Gender diverse (please state) | | |
| Male | Female |
| **Optional** | | Marital status | | | | Occupation |
| **How did you hear about us?** | |  | | | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |

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| --- | --- | --- | --- | --- |
| **\*Contact Details** |  |  |  | |
| Mobile Phone | Home Phone | Email Address | |
| **\*Emergency Contact /NOK** |  | |  |  |
| Name | | Relationship | Mobile (or other) Phone |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 | |
| **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 1 practice at a time in NZ* | | | | | |
|  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 | **Primary Language Spoken:** |
| **IWI** |
| \* Smoking status (if over 15) Never smoked 🞎 Ex-smoker 🞎 Greater than 15months🞎 less than 12 months 🞎 Current smoker 🞎  Would you like support to quit? Yes 🞎 No 🞎 |
| I authorise CFHC to contact me via text message  I authorise to contact me via email (non-secure). |

Primary Health Services Provider Enrolment Form - Version August 2016

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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 **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 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*) |

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| **\*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 Central Family Health Care I will be included in the enrolled population of Comprehensive Care,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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **\*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) | | |

**NEW PATIENT QUESTIONAIRRE**

*If you prefer not to answer any question – please leave blank*

*If you can`t remember the exact date – give an estimate*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

|  |  |  |
| --- | --- | --- |
| Have you had any operations?  (include tonsils, appendix, male or female sterilisation) | Year |  |
| Have you ever been into Hospital for any other illnesses? | Year |  |
| Have you ever seen a specialist about any other problem or had any other special tests?  Please give details e.g. ECG, Colonoscopy | Year |  |
| Do you have any long term illnesses or disability? Please give details e.g. raised blood pressure, diabetes, asthma | Year |  |
| Are you fully immunised?  When was your last tetanus vaccination? | Year |  |

**Medications**

|  |  |
| --- | --- |
| Please list any current medication |  |
| Are you allergic to any medications?  If so, please give details |  |

Do you have any allergies?

**Family History**

Please circle below and provide details

|  |  |  |  |
| --- | --- | --- | --- |
| Asthma | High blood pressure | Stroke | Heart disease |
| Glaucoma | Bowel cancer | Breast cancer | Any other inherited disease |

**Lifestyle**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you smoke currently? | Yes/No | Number of cigarettes per day |  |
| Have you ever smoked? | Yes/No | What year did you stop? |  |
| Do you drink alcohol? | Yes/No | How much | ……per day……..per week |
| What sort of exercise do you do? |  | How often? |  |

**Women**

|  |  |
| --- | --- |
| Number of children | Year/s born |
| Other pregnancies | Year/s |
| Form of contraception (if relevant) |  |
| Last cervical smear | Month Year |
| Last mammogram | Month Year |



Central Family Health Care

Patient Credit Terms and Conditions of Trade

The following Terms of Trade apply to services provided by Central Family Health Care to its patients. By signing, you hereby agree to the Terms and Conditions of Trade as stated:

1. Any changes to the Terms and Conditions of Trade need to be agreed to in writing by both parties.
2. Central Family Health Care expects a high standard of behaviour from our patients and our staff at all times. Patients and staff are all subject to CFHC Harassment and Bullying Policy in order to protect and foster development of the therapeutic relationship.
3. No staff member of CFHC Doctors may agree to any terms other than as written in this contract.
4. Prices Include GST unless otherwise stated.
5. Prices quoted for services may be adjusted from time to time, and the customer hereby agrees to pay any such adjusted price, e.g. in instances where cost of goods increases, government surcharges increases, errors or omissions by CFHC or its representatives.
6. Unless otherwise agreed, all services shall be paid for on the date of service.
7. Payment shall be accepted in the form of cash, cheque, direct credit or direct debit.
8. Where it is agreed that payment need not be paid on the day of service, it shall be paid within 7 days of the date of service.
9. CFHC may withhold further provision of service where there is any outstanding amount due.
10. Where patients are in breach of agreed payment terms, we may disclose this information to debt collection agencies and legal proceedings may follow. This may result in your name and address being entered into the Computer Bureau default listing which will have an impact on your credit rating.
11. Interest may be charged on overdue accounts at a rate to be decided by CFHC from time to time.
12. Costs incurred to recover outstanding monies will be charged to the customer.
13. Termination of the contract may apply where there is non-payment without prejudice to any claims CFHC may possess.
14. No goods supplied by CFHC may be returned for credit.
15. Supply of goods for personal use will be covered by the Consumer Guarantees Act 1993.
16. Variations to the Terms of Trade may occur from time to time, and CFHC will notify the patient by way of invoice – receipt of which shall be deemed to be acceptance by the patient.

Applicants signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff signature …………………………………………………………………………..

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_





**ManageMyHealth Consent Form**

I understand that my access to this Portal will not affect the current level of care I am already receiving from Central Family Health Care. I acknowledge that I have read and fully understand this Consent Form. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from CFHC should I decide against using the patient portal. I have read and agree to adhere to the policies set out in **ManageMyHealth Policy and Procedures enclosed as well as any other** instructions or guidelines that my physician may impose for online communications. It is my responsibility to notify CFHC if there is a change in my email account or I feel that my secure password has been breached. I agree not to hold CFHC or any of its staff liable for network infractions beyond its control. It is my responsibility to act on any messages I receive in my MMH inbox and any emails I have receive from MMH.

**The patient portal is only available to registered and enrolled patients.**

**Please print all information clearly**

**Full Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My Confidential e-mail address (personalised/individual email) is**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My best cell phone number is** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_