53-65 Commercial Road, Helensville 0800; PO Box 114, Helensville 0840
Phone 09 420 8400 Fax 09 420 7523 Email: admin@kaiparamed.co.nz
Owned by South Kaipara Medical Centre LP

In order to complete your enrolment and obtain government funding for subsidised healthcare we are required to sight one **or more** (see below) of the following original documents:

NZ Citizens

- Passport, NZ Birth Certificate or Certificate of Citizenship.
- If only a Birth Certificate or Certificate of Citizenship is available, we will require another form of photo I.D (e.g. Driver's License), to confirm your identity.

NON-NZ Citizens

- Passport with Permanent residency Visa or work Visa stamp(s) covering at least 2 consecutive years.
  Note: *If you have less than 2 years of Visas you will NOT qualify for Government subsidised health care. We will therefore have to charge you as a visitor to New Zealand.*

ALL New Patients

To verify your address, we also require 2 separate letters/documents, with your name and address on them. (E.g. bank statement header, phone, or power bill).

KAIPARA MEDICAL CENTRE ENROLMENT FORM

53-65 Commercial Road, Helensville 0800, PO Box 114, Helensville 0840
Phone: (09) 420-8400 Fax: (09) 420-7523 Email: admin@kaiparamed.co.nz GP2GP/EDI: KAIPRAMC

Dr Phillip Barter	36882	Dr Dean Foster	19175	Dr Martine Gerritsen	84167
Dr Kathryn Elcock	58048	Dr Vaughan Lock	38649	Dr Tomos Longworth	58437

NHI:	SURNAME	FIRST NAME	OTHER NAMES

DATE OF BIRTH:	PLACE OF BIRTH	COUNTRY OF BIRTH

□ MALE □ FEMALE □ GENDER DIVERSE – PLEASE STATE	EMAIL ADDRESS:	OCCUPATION:

STREET ADDRESS:	SUBURB	CITY	POSTCODE

WORK PHONE NUMBER:	HOME PHONE NUMBER	MOBILE NUMBER

NEXT OF KIN/EMERGENCY CONTACT	NAME	PHONE NUMBER	RELATIONSHIP

Community Services Card. □Yes □No	**Number:**	**Valid Date:**	**Expiry Date:**
High User Health Card □Yes □No	**Number:**	**Valid Date:**	**Expiry Date:**

***Ethnicity Details**
Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you

- ○ New Zealand European
- ○ Maori Iwi: _____
- ○ Samoan
- ○ Cook Island Maori
- ○ Tongan
- ○ Niuean
- ○ Chinese
- ○ Indian
- ○ Other (such as Dutch, Japanese, Tokelauan).

Please state: _____

Patient Survey
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.

Patient Survey Contact Details: As provided above ☐

Alternative contact details:

I do not wish to participate in the Patient survey ☐

TRANSFER OF YOUR MEDICAL RECORDS: *In order to get the best care possible, I agree to Kaipara Medical Centre obtaining my records from my previous Doctor. I also understand that I will be removed from the previous practice register. Please tick which you prefer.*

☐ **Yes, please request transfer of my records** ☐ **No transfer** ☐ **Not applicable**

Previous Doctor / Medical Centre	Address / Location

Practice Use Only: Photo ID Sighted: Passport ☐ Driver's Licence ☐ P.K. (Personally Known) ☐ Child added to spreadsheet ☐

Staff initial: _____

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, if requested, I can provide proof of my eligibility	☐

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**	☐ **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)		

KAIPARA MEDICAL CENTRE – NEW PATIENT MEDICAL QUESTIONNAIRE

Please complete one form for <u>each member</u> 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	☐ Yes	☐ Yes	Blood clot	☐ Yes	☐ Yes
High blood pressure	☐ Yes	☐ Yes	Stroke	☐ Yes	☐ Yes
Heart disease or problems	☐ Yes	☐ Yes	High cholesterol	☐ Yes	☐ Yes
Heart Attack <60yr >60yr	☐ Yes	☐ Yes	Migraine	☐ Yes	☐ Yes
Asthma	☐ Yes	☐ Yes	Epilepsy	☐ Yes	☐ Yes
Other lung or respiratory disease or problems	☐ Yes	☐ Yes	Breast cancer	☐ Yes	☐ Yes
Kidney disease or problems	☐ Yes	☐ Yes	Other cancer	☐ Yes	☐ Yes
Liver disease or Hepatitis	☐ Yes	☐ Yes	Glaucoma	☐ Yes	☐ Yes
Bowel disease or problems	☐ Yes	☐ Yes	Rheumatic Fever	☐ Yes	☐ Yes
Joint disease or problems, arthritis	☐ Yes	☐ Yes	Tuberculosis (TB)	☐ Yes	☐ Yes
Depression and/or anxiety	☐ Yes	☐ Yes	Eczema	☐ Yes	☐ Yes
Other mental health illnesses	☐ Yes	☐ Yes	Hay Fever	☐ Yes	☐ 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 how many / day _____

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

Have you ever smoked? ☐ Yes ☐ No If Yes 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

<u>Women:</u> (*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?_____

Patient Signed:_____ **Date:** _____

MANAGE MY HEALTH – PATIENT PORTAL REGISTERATION FORM

You must complete this form and provide photo proof of identity (if not upon enrolment) in order to register yourself with Kaipara Medical Centre patient portal.

Each applicant must complete their own form and register with a unique email address, the same email used at the practice. Once you have registered you will receive a confirmation email with your username and password. The 'Patient Guide to the Portal will instruct you how to use Manage My Health.

Full Name: _____

Date of Birth: _____

Address: _____

Email: _____

Contact Phone: _____

I am registering a child/children under 16 years of age who are legally in my care. Each person must have their own email address to register with MMH

Children to be added:

Name	Date of Birth	Childs email address

Signed: _____ Date: _____
Above Patient or Parent/Guardian of Patient (Delete as applicable)

Please note: it is a condition of use that patients using the portal services have no outstanding invoices. Portal services may be removed if your account becomes overdue.

Practice Use Only:

Photo ID Sighted:

Passport ☐ Driver's Licence ☐ P.K. (Personally Known) ☐ Child added to spreadsheet ☐

Staff initial: _____