MILLWATER MEDICAL | SILVERDALE MEDICAL | WEITI CREEK MEDICAL

ProCARE ENROLMENT FORM: ProCARE

THIS PROCESS REQUIRES VALID ID – Passport or Birth Certificate.

LAST NAME:	**FIRST NAME:**	Mr Mrs Ms Miss Mast Other:
MIDDLE NAME:	**PREFERRED NAME:**	**DATE OF BIRTH:**
HOME ADDRESS:		
POSTAL ADDRESS: *(if different from home)*		
DAY PHONE:	**NIGHT PHONE:**	**MOBILE PHONE:**

Do you wish to receive txt messages? YES ☐ NO ☐

Do you wish to receive emails? YES ☐ NO ☐

☐ **Male**
☐ **Female**
☐ **Not Specified**

PREFERRED DOCTOR:

Email Address:

Ethnicity Details
Which ethnic group (s) do you belong to?
Tick the space or spaces which apply to you

- ○ NZ European
- ○ NZ Maori
- ○ Samoan
- ○ Cook Island Maori
- ○ Tongan
- ○ Niuean
- ○ Chinese
- ○ Indian
- ○ Other – *Please State*: _____

Iwi/Tribe/Hapu:

Country of Birth:	Town of Birth:
Marital Status: *(Optional)*	**Primary Language Spoken:**

Occupation _____

Employers Name _____

Employers Address _____

Employers Phone number _____

Emergency Contact:

Name:

Day Phone:

Mobile Phone:

Relationship to you:

How did you hear about us?

If you have **Southern Cross**, Please provide membership number here:

_____

Do you wish to sign up to the MY INDICI ONLINE PORTAL?

This feature allows you to book online, view results, order repeat prescriptions and direct message the clinic.

YES ☐ **NO** ☐

TRANSFER OF RECORDS

In order to get the best care possible, I agree to the Practice obtaining my records from my previous doctor within New Zealand. 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 New Zealand.
If your records are overseas, it is your responsibility to obtain them.

Previous Doctor and/or Practice Name:	**If you do not state a previous Doctor and/or Practice Name, then we will be unable to transfer your records.**

Terms of Trade:

Payment is required at the time of consultation we do not extend credit. If **you** are the **Registered Account Holder**, we will hold **you financially liable** for **all** people listed as account members until you notify us in writing of any changes. If, for some reason we are required to issue an invoice, where your account remains **unpaid for 7 day's we will consider this overdue**. We will notify you by text as a courtesy to the most recent mobile number we have on record. We will invoke debt collection procedures from **14 days** without further notification. When we lodge your debt for collection, you will incur our **processing fee of $25.00** plus the Agency Recovery Fee.

My Declaration of entitlement and eligibility

1. **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 a resident in New Zealand for at least 183 days in the next 12 months. ☐

I am eligible to enrol because:

2. **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**" ☐

If you are **not a New Zealand citizen** please tick which eligibility criteria applies to you:

- I hold a resident visa or a permanent resident visa (or a resident permit if issued before December 2010.) ☐
- I am an Australian citizen or Australian permanent resident AND able to show I have been in New Zealand or intent to stay in New Zealand for at least 2 consecutive years. ☐
- 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. ☐
- I am an interim visa holder who was eligible immediately before my interim visa started. ☐
- 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. ☐
- I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one criterion in the clauses above ☐
- 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 am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme. ☐
- 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: ☐

VALID ID- If born **overseas** this is a **Passport and Visa Copy, If born in New Zealand Passport or Birth Certificate.**

My agreement to the enrolment process

I intend to use this practice as my regular and on-going provider of general practice / health care services.

I understand that by enrolling with Silverdale and Millwater Medical Centre, I will be included in the enrolled population of the ProCare PHO, 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 ProCare provides along with the PHO's name and contact details along with the use for Health Privacy 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.

1. **I understand and accept that Silverdale Medical do not wish to store my Hard Copy Medical Records**. When my records are received from my previous Doctor, Silverdale Medical will store the electronic medical records only. The hard copy records will be returned to me or to authority if under 16 years.
2. 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.

Name or Authorised Name:	**Relationship if Authority:**
Signature:	**Date:**

7 Polarity Rise, Silverdale 0932 **Ph:** 09 427 9997 **Fax:** 09 427 8080 **Email:** support@silverdalemedical.co.nz
EDI: silvermc **NZMC:** 0000 **Drs Name**: Silverdale Medical

SILVERDALE MEDICAL

MILLWATER MEDICAL

NEW PATIENT QUESTIONNAIRE

Last Name:	**First Name:**	**DOB:**

Do you have any of the following (Please tick)

Diabetes	☐	Stroke	☐
Asthma	☐	Cancer of any sort	☐
Heart Trouble	☐	Operations	☐
Raised Blood Pressure	☐		

Are you aware of anyone in your family e.g. parents, grandparent with any of the above conditions? If so, please list the disease and family member below:

Please list any operations and approximate dates:

Any other significant illnesses/hospital admissions (excluding operations):

Please list all current medications:

Are you allergic to any drugs: Yes (please list) ☐ No ☐	Name of Drug: Reaction Name of Drug: Reaction:

Have you ever smoked: Yes ☐ No ☐	No. smoked per day? When did you stop?
Do you currently smoke: Yes ☐ No ☐ No. per day?	Have you ever considered giving up smoking? Yes ☐ No ☐
Would you like us to contact you regarding giving up smoking? Yes ☐ No ☐	

Do you drink alcohol? Yes ☐ No ☐	How often do you drink?
When you drink, how many drinks do you have in a typical session?	How often do you have 5 or more drinks on one occasion?

<u>Vaccination History:</u> When was your most recent Tetanus booster? Would you like an annual Flu Vaccine? Yes ☐ No ☐ For children – are all scheduled vaccines up to date? Yes ☐ No ☐	<u>Women: Please answer the following;</u> When was your last cervical smear? Last Mammogram? Where? Contraception (if relevant)

Is there any other additional information you would like us to know before we receive your medical records?

Silverdale Medical – 7 Polarity Rise, Silverdale, 0932 **Phone:** 09 427-9997 **Fax:** 09 427-8080

Doctors Name: Silverdale Medical N**ZMC:** 0000 **EDI:** silvermc **Member of ProCare PHO**