ENROLMENT FORM

SILVERDALE MEDICAL — MILLWATER MEDICAL

Legal Name:	Family Name:	Given Name:
Title:	Middle Name(s):	Preferred Name:
Physical Address:	House (or RAPID) Number and Street Name	Suburb/Rural Location
	Town/City	Postcode

Work Phone:	**Home Phone:**
Mobile Phone:	**Do you wish to receive txt messages?** ☐ Yes ☐ No

MY DECLARATION OF ENTITLEMENT AND ELIGIBILITY

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)*	☐
	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*	☐

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*)

Date Of Birth:	**NHI:** *(Office use only)*
☐ **Male** ☐ **Female** ☐ **Gender Diverse** (Please State)	**Preferred Doctor:**
Ethnicity Details: Which Ethnic Group you belong to? ☐ New Zealand European ☐ Maori ☐ Samoan ☐ Cook Island Maori ☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian ☐ Other (such as Dutch, Japanese, Tokelauan) *Please state:*	
Enrolment Date:	**Do you have Medical Insurance?** ☐ **Yes** ☐ **No**
Insurers Name:	**Policy/Membership Number:**
How did you hear about us?	

ENROLMENT FORM

Your Postal Address: (If different to Physical)	House (or RAPID) Number and Street Name	Suburb/Rural Location
	Town/City	Postcode

Email Address:		
Marital Status:	**Place of Birth:**	**Country of Birth:**

Occupation:	Employer Name:	Occupation Address: House (or RAPID) Number and Street Name
Suburb/Rural Location		Town/City
Occupation Day Phone:		Occupation Title:
Emergency Contact:	Family Name:	First Name:
Address: House (or RAPID) Number and Street Name		Suburb/Rural Location
Town/City		Day Phone:
After Hours Phone:		Relationship:

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:**	

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 Silverdale and Millwater Medical Centre I will be included in the enrolled population of Waitemata 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 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 along with the Use of 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.

- 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 record only. The hard copy record will be returned to me.
- If my record is 20 pages or less, Silverdale Medical will scan it into their Practice Management System and then destroy the hard copy.
- If my record is more than 20 pages Silverdale Medical will return it to me by Courier Service to my physical address.
- Delivery to authority if under 16 years

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
Authority Details	Parent of a child under 16 years of age or Basis of authority		
Community Services Card and High User Health Card Holders please present your card to reception.			

Silverdale Medical– 7 Polarity Rise, Silverdale, 0932 **Phone:** 09 427-9997 **Fax:** 09 427-8080 **Doctors Name:** Silverdale Medical **NCMC:** 0000 **EDI:** silvermc

Member of Waitemata PHO

SILVERDALE MEDICAL

ENROLMENT FORM

MILLWATER MEDICAL

NEW PATIENT QUESTIONNAIRE

Name:____**DOB:**____________________________________

I agree to receiving text messages from Silverdale Medical concerning my health. Yes / No

Do you have any of the following (please tick)

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

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 / No (If yes please list)

Name of Drug: __________________________ Reaction:____

Name of Drug: __________________________ Reaction:____

Have you ever smoked? Yes / No (If Yes) No. Per Day?____________________________________

When did you stop?________________________________

Do You Currently Smoke? Yes / No No. per day?______________________

Have you considered giving up smoking? Yes / No

Would you like us to contact you to discuss this further? Yes / No

ENROLMENT FORM

NEW PATIENT QUESTIONNAIRE CONTINUED

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 / more drinks on one occasion?____________________

Vaccination History:

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

Women: Please answer the following

When was your last cervical smear?____________________

Last mammogram?____________________Where?____________________

Contraception (if relevant)____________________

Number of pregnancies?____________________**Number of children**____________________