

ENROLMENT FORM

65 Clyde Road, Browns Bay
P: 09 479 4834
F: 09 478 5738
EDI: bbfd
E: reception@bbfd.co.nz

Provider: GP2GP			NHI (Office use only)
Dr Sheryl Howarth 19646	Dr Shashi Bhuthoji 22344	Dr Steven Hall 44193	
Dr David Raubenheimer 10486	Dr Lynne Potter 12996		

*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	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)	
Optional	Marital status			Occupation

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

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

Community Services Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number
High User Health Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number

Transfer of Records	<i>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</i>		
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor and/or Practice Name		Address / Location

Ethnicity Details Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	<input type="radio"/> New Zealand European <input type="radio"/> Maori <input type="radio"/> Samoan <input type="radio"/> Cook Island Maori <input type="radio"/> Tongan <input type="radio"/> Niuean <input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state	Primary Language Spoken:
		IWI
	<p>* 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.</p> <p><input type="checkbox"/> I authorise Browns Bay Family Doctors to contact me via text message</p> <p><input type="checkbox"/> I authorise Browns Bay Family Doctors to contact me via email (non-secure)</p>	

*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)

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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)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>

I confirm that I have provided proof of my eligibility

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Evidence sighted (Office use only)

*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 Browns Bay Family Doctors 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.

Acceptance of terms and conditions of credit:

1. All accounts are payable within 14 days following the date that services are provided;
2. I shall pay or reimburse you all costs and/or expenses incurred by you instructing a solicitor and/or debt collecting agency to recover any amount over due for payment by me;
3. An administration fee of \$20.00 per statement may be added;
4. I agree to be bound by the above terms and conditions in respect to this and all future transactions

Signatory Details	*		<input type="checkbox"/>	<input type="checkbox"/>
	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)			

Browns Bay Family Doctors Medical Questionnaire

Name: _____ Date: _____

Address: _____

Home Ph: _____ Work Ph: _____ Mobile: _____ DOB: _____

Occupation: _____ Email: _____

Next of Kin: _____ Relationship: _____ Phone: _____

The questions within this questionnaire relate to your health and provide us with vital information to help us with your healthcare, thank you for taking the time to complete it.

Past Medical Problems: Have you ever had;

	Yes	No	Don't Know		Yes	No	Don't Know
High blood sugar				High blood pressure			
Angina or heart attack				Allergies including medications (give details below)			
Asthma or lung disease				Stroke or transient ischaemic attack			
High cholesterol				Heart murmur			
Rheumatic fever				Cancer			
Depression				Hepatitis			
Cataract							
Operations (give details below)				Admissions to hospital (give details below)			

Please give details of these or **other medical problems**:

Please list medications below:

Are you a ☐ smoker ☐ ex-smoker ☐ never smoked

If current smoker how many cigarettes per day for how many years ?

If smoker, would you like help or advice to stop? Yes ☐ No ☐

If ex-smoker, when did you stop: , prior to stopping how many cigarettes did you smoke per day for how many years ?

Please indicate how much alcohol you drink on average drinks per week/day

Your Family:

Has anyone in your family (mother, father, brother, sister or children) EVER had:

	Yes	No	Who		Yes	No	Who
Hepatitis				Diabetes			
Heart trouble				Cancer			
Blood pressure				Glaucoma			
Asthma				Other serious illness			

Please give details:

Women only:

Have you ever had a smear test?

Yes / No When? Where?

Have you ever had an abnormal smear test?

Yes / No

Have you had any children?

Yes / No

Have you ever had a baby more than 4kg / 9lb?

Yes / No

Have you ever had a mammogram?

Yes / No When? Where?

Men over 50yrs only:

Have you ever had a prostate check?

Yes / No When? Where?