BROWNS BAY FAMILY DOCTORS
OLD VALUES - NEW VISION

ENROLMENT FORM

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

comprehensive care

Medtech
NHI Valid
Enrol Valid
Scanned
Faxed to GP
Notes Rec'd
List

Please circle preferred provider:

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

*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		☐ Male ☐ Female	☐ 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	☐ 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

* **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 authorise Browns Bay Family Doctors to contact me via text message

☐ I authorise Browns Bay Family Doctors to contact me via email (non-secure)

*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*)

*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	* 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_____?

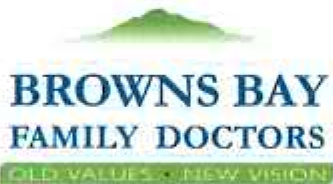
Please indicate how much alcohol you drink on average _______ drinks per week/day

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 / 9llb? 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?



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Dr. Steve Hall
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Consent to Receive Test Results and other Personal Health Information via ConnectMed

ConnectMed is a secure online website that provides as easy, safe and convenient way for me to manage more of my own health care.

I understand that signing this form gives Browns Bay Family Doctors full permission to use the email that I have provided below to register me for ConnectMed Level 2 access.

I acknowledge that I have had the opportunity to discuss any questions or concerns that I have regarding receiving my personal health information (including test results) via ConnectMed with staff at Browns Bay Family Doctors.

I ____ DOB ____________ give my full permission to receive my personal health information (including test results) via ConnectMed. I realize that this communication will be sent over a secure network, but that confidentiality is not guaranteed. By signing this consent, I absolve Browns Bay Family Doctors of any liability and wrong-doing should my information be accessed by any unauthorized persons.
Furthermore, the email address I have provided below has been nominated by myself and is the address to which I request all notifications regarding my personal health information from ConnectMed be sent. I understand and accept that it is my responsibility to notify Browns Bay Family Doctors and sign a new consent form should this email address change in the future.
I understand that it can take up to seven working days after having blood tests for the results to become available in ConnectMed. I acknowledge that checking my results earlier than this may not provide me with a complete picture of my health. I also accept that it can take more than two weeks for some other tests (such as cervical smears and histology specimens) to be reported on. I agree to check my test results in ConnectMed after two weeks as well.

Email Address: ____

Cell Phone Number: __________________________________

Patient Signature : ____________________________________ Date: _______________