FOUR PEAK HEALTH	**ENROLMENT FORM**	**16 COX STREET, GERALDINE, South Canterbury** **PHONE: 03 6938880 FAX: 03 6939919** **4peakhealth@gmail.com**

	Kevin Moginie 18533 **Elina Bashkatova 85937**	**EDI: geraldmc**	NHI *(Office use only)*

Legal Name	(Title)	Given Name	Other Given Name(s))	Family Name
Other Name(s) (eg. maiden name) Please tick the name you prefer to be known as				
Birth Details		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender	☐ Male ☐ Female	☐ Gender diverse (please state)		Occupation
Usual Residential Address		House (or RAPID) Number and Street Name	Suburb/Rural Delivery	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		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.*		
	☐ 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

_____

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 ☐ **(or)**

Alternative Mobile Phone

Alternative Email Address

☐ I do not wish to participate in the Patient Survey

Manage My Health – Patient Online Access

☐ I do not wish to be **automatically registered for Manage My Health** using the **email address above.**

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 entitlement 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	☐	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 Four Peak Health I will be included in the enrolled population of Community and Primary Services 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 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)		

Medical History

Family History

Has any blood relative suffered from any of the following diseases?

☐ **Asthma** ☐ **Eczema** ☐ **Diabetes** ☐ **Epilepsy** ☐ **Tuberculosis**

☐ **High Blood Pressure** ☐ **Heart Disease** ☐ **Cancer** ☐ **Glaucoma** ☐ **High cholesterol**

☐ **Mental Illness (give detail) _____**

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Personal History Have you suffered from any of the following?

☐ **Asthma** ☐ **Eczema** ☐ **Hay fever** ☐ **Migraine** ☐ **Diabetes** ☐ **Epilepsy**
☐ **Tuberculosis**

☐ **Mental illness** ☐ **High Blood pressure** ☐ **High Cholesterol** ☐ **Cancer** ☐ **Stomach or duodenal**

☐ **Tropical Disease _____**

☐ **Other major illness or injuries (Specify)**
_____

Have you ever been in hospital as an in-patient? Yes☐ No☐ If yes, for what illness or operation? _____

Are you allergic to any medicines, tablets or injections? Yes☐ No☐ If yes, to what? _____

What medicines or tablets do you take regularly? _____

_____

Are you physically disabled? Yes☐ No☐ Please give brief details? _____

Immunisations: Did you have all the usual childhood immunisations? Yes☐ No☐

Year of last immunisation (if known) against: ☐Tetanus ☐Hepatitis ☐Rubella

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****Smoking is an important factor influencing health Please tick the smoking status that applies to you:**

No never:☐ Yes:☐ approximately____per day Ex-smoker:☐ I quit_____date.

Would you Like help to Quit: Yes☐ No☐

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****For Females only:**

Have you had a cervical smear? Yes☐ No☐ If 'Yes' date or month of smear____ Results of smear: Normal☐ Abnormal☐

Have you had a Mammogram? Yes ☐No☐ If 'No' are you between the ages of 45 and 70 would you like to have one? No☐
Yes☐

Health Information Privacy Statement

I understand the following:

Access to my health information

I have the right to access (and have corrected) my health information under Rules 6 and 7 of the Health Information Privacy Code 1994.

Visiting another GP

If I visit another GP who is not my regular doctor I will be asked for permission to share information from the visit with my regular doctor or practice.

If I am under six years old or have a High User Health Card, or a Community Services Card, and I visit another GP who is not my regular doctor, he/she can make a claim for a subsidy, and the practice I am enrolled in will be informed of the date of that visit. The name of the practice I visited and the reason(s) for the visit will not be disclosed unless I give my consent.

Patient Enrolment Information

The information I have provided on the Practice Enrolment Form will be:

o held by the practice

o used by the Ministry of Health to give me a National Health Index (NHI) number, or update any changes

o sent to the PHO and Ministry of Health to obtain subsidized funding on my behalf

o 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.

Health Information

Members of my health team may:

o add to my health record during any services provided to me and use that information to provide appropriate care

o share relevant health information to other health professionals who are directly involved in my care

Audit

In the case of financial audits, my health information may be reviewed by an auditor for checking a financial claim made by the practice, but only according to the terms and conditions of section 22G of the Health Act (or any subsequent applicable Act). I may be contacted by the auditor to check that services have been received. If the audit involves checking on health matters, an appropriately qualified health care practitioner will view the health records.

Health Programmes

Health data relevant to a programme in which I am enrolled (e.g. Breast Screening, Immunisation, Diabetes) may be sent to the PHO or the external health agency managing this programme.

Other Uses of Health Information

Health information *which will not include my name but may include my National Health Index Identifier (NHI)* may be used by health agencies such as the District Health Board, Ministry of Health or PHO for the following purposes, as long as it is not used or published in a way that can identify me:

o health service planning and reporting

o monitoring service quality, and

o payment.

Research

My health information may be used for health research, but only if this has been approved by an Ethics Committee and will not be used or published in a way that can identify me.

Except as listed above, I understand that details about my health status or the services I have received will remain confidential within the medical practice unless I give specific consent for this information to be communicated.