



CROMWELL
MEDICAL CENTRE

Cromwell Medical Centre
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EDI: cromwell

NEW PATIENT ENROLMENT FORM

		NHI		
Title	Mr Mrs Ms Miss Dr Mx	First Name(s)	Family Name	
Occupation		Other Names Known By (e.g. maiden name)		
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary		Place / country of birth	
Physical Address	Street or Rapid (rural) number	Name of Street	Date of Birth	____ / ____ / ____ Day Month Year
	Suburb	Postcode	Community Services Card	YES / NO Card No: _____ Expiry Date: _____
Postal Address			High User Health Card	YES / NO Card No: _____ Expiry Date: _____
Contact Details	Day Phone:		Cell Phone:	
	Register on portal Health365 YES / NO		Email:	
Emergency Contact	Name of Person:		Relationship to you:	
	Day Phone:		Cell Phone:	

Which ethnic group do you belong to? Mark the space or spaces which apply to you		Please circle your smoking status:		Never Smoked Trying to give up Quit date:	Smoker Ex-Smoker
New Zealand European		Is there any other information that you would like us to know?			
Māori					
Samoan					
Cook Islands Maori					
Tongan					
Niuean		Transfer of Records			
Chinese		In order to get the best care possible, I agree to Cromwell Medical Centre obtaining my records from my previous Doctor. I also understand that I will be removed from their Practice register and that an electronic transfer fee of \$5 may be charged to my account:			
Indian		Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/> Fee Charged <input type="checkbox"/>			
Dutch		Doctor's Name:			
Other such as Japanese, Tokelauan etc Please state: _____		Address / Location:			
OFFICE USE ONLY: S/S UPDATED		○			

Enrolment in the Practice / Primary Health Organisation (PHO)

I intend to use **CROMWELL MEDICAL CENTRE** as my regular and ongoing provider of general practice/ GP/ First Level primary health care services.

I understand that Visitor charges apply for my consultations until central funding is transferred to this enrolment.

I am entitled to enrol because I am residing permanently in New Zealand¹ and meet one of the following eligibility criteria:

a) I am a New Zealand citizen OR	Yes / No
b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	Yes / No
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	Yes / No
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)	Yes / No
e) I am an interim visa holder who was eligible immediately before my interim visa started	Yes / No
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	Yes / No
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	Yes / No
h) I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder	Yes / No
i) I am a NZ Aid Programme student studying in NZ and receiving Official Development Assistance funding (or the partner/child under 18 of a NZ Aid Programme student studying in NZ, receiving Official Development Assistance funding)	Yes / No
j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	Yes / No
k) I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund.	Yes / No

I confirm that, if requested, I can provide proof of my eligibility.

My agreement to the enrolment process

I choose to enrol with Cromwell Medical Centre as my regular and on-going provider of general practice / GP / First Level primary health care services.

I understand that by enrolling with Cromwell Medical Centre I will be enrolled with the Primary Health Organisation (PHO) this practice belongs to, and my name, address and other identification details will be included on both the Cromwell Medical Centre register of enrolled patients and the PHO Enrolment Register.

I understand that if I visit another provider where I am not enrolled I may be charged a higher fee.

I have been given information about the benefits of enrolment in Southern PHO, and PHO contact details.

I have read and I agree with the Health Information Privacy Statement (Page 4 of Enrolment Form).

I agree to inform the practice of any changes in my eligibility.

SIGNATURE:	DATE / /
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OR Parent or caregiver to sign if you are under 16 years

Signed by <u>AUTHORITY</u> ² :	DATE: / /
Full Name of Authority:	
Relationship:	Contact Phone Number:
Address:	

¹ The definition of residing in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months.

² An authority is the legal right to sign for other persons if for some reason they are unable to consent on their own behalf.

MEDICAL HISTORY DETAILS

FAMILY NAME:		MALE / FEMALE	
GIVEN NAMES:		Mr Mrs Ms Miss Dr	
DOB:	ETHNICITY:	DR:	
ADDRESS:			
EMPLOYMENT DETAILS:			
CURRENT EMPLOYER:		OCCUPATION:	
ADDRESS:		PHONE NO:	
SMOKING STATUS: If you do smoke, do you wish to have smoking cessation advice? Please circle: YES / NO			
How many cigarettes do you smoke a day (please tick)			
Never Smoked <input type="checkbox"/>	Ex Smoker <input type="checkbox"/>	Finish Date	
1 – 9 per day <input type="checkbox"/>	10 – 20 per day <input type="checkbox"/>	1 – 2 Smokes <input type="checkbox"/>	
ALCOHOL CONSUMPTION:			
How many alcoholic beverages do you drink per day (please tick)			
Non Drinker <input type="checkbox"/>	Less than one drink <input type="checkbox"/>	1 – 2 drinks <input type="checkbox"/>	
3 – 6 drinks <input type="checkbox"/>	7 or more drinks <input type="checkbox"/>	Other	
CURRENT MEDICAL INFORMATION:			
Allergies: Medications and Foods			
Long Term Medications: (include supplements and vitamins)			
Medical Conditions: Asthma / Diabetes etc.			
WOMEN:	Date of last cervical smear:		Date of last mammogram:
FAMILY HISTORY:			
Do you have a family history of diabetes? YES / NO		IF YES What is that person's relationship to you?	
How is their diabetes managed?	Diet <input type="checkbox"/>	Tablets <input type="checkbox"/>	Insulin <input type="checkbox"/>
<i>Any family history of:</i>	<i>Relationship to You</i>	<i>Age of Onset</i>	
High blood pressure			
Heart attacks			
Stroke			
Cancer (state type)			
Other family illnesses (please specify)			

HEALTH INFORMATION PRIVACY STATEMENT

- **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 have a High User Health Card or Community Services Card and visit another GP who is not my regular doctor, he/she can make a claim for a subsidy, and Cromwell Medical Centre 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:

- held by Cromwell Medical Centre
- used by the Ministry of Health to give me a National Health Index (NHI) number, or update any changes
- sent to the PHO and Ministry of Health to obtain subsidised funding on my behalf
- 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:

- add to my health record during any services provided to me and use that information to provide appropriate care
- share relevant health information with 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 Cromwell Medical Centre, 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:

- health service planning and reporting
- monitoring service quality
- 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.

ENQUIRIES

If you have concerns about any matter relating to your health information, please ask to speak to our Privacy Officer.



Privacy and your health information

Cromwell Medical Centre follows the rules set out below whenever we collect, use, store or disclose information about your health.

COLLECTING YOUR HEALTH INFORMATION

When we collect health information from you we will:

- Only collect the information for the purpose of treating you (or for some related purpose).
- Collect the information directly from you unless you have authorised us to collect the information from someone else (or we have some other lawful reason for collecting the information & what we will do with it).
- Tell you why we are collecting the information and what we will do with it.

USING YOUR HEALTH INFORMATION

We will not use your health information for any purpose other than for the purpose of treating you unless we get your consent or we will use your information in a way that doesn't identify you (or where we have some other lawful reason for doing so).

STORING YOUR HEALTH INFORMATION

We will store your health information securely so that only authorised people can access or use your information.

DISLOSING YOUR HEALTH INFORMATION

We will not disclose your health information to anyone without your consent unless we have a lawful reason for doing so.

ACCESS AND CORRECTION OF YOUR HEALTH INFORMATION

- You can ask us to confirm whether we hold information about you. If we hold information about you, you have the right to access the information.
- You can ask us to correct any information that we hold about you if you think that the information is inaccurate. If we refuse to correct your information, you can ask us to put a note on your information that states that you have asked for the correction to be made.

ENQUIRIES

If you have concerns about any matter relating to your health information, please ask to speak to our Privacy Officer.