

New Patient Form

Millhouse Integrative Medical Centre

128 Millhouse Drive
Howick
Auckland 2013

Phone: 537 4980
Fax: 5375476
EDI: millhsed



Surname: _____

First Name: _____

Preferred Name: _____

Title: Mr / Mrs / Ms / Miss / Master (please circle)

Residential Address: _____

Postal Address: (if different) _____

Work Phone: _____

Cell Phone: _____

Home Phone: _____

Do you authorise your results/recalls to be sent
via text? Yes / No

Date of Birth: _____

NHI: _____

Name of Doctor with whom you wish to enrol: _____

Are you New Zealand Resident / Non Resident / visitor to NZ / Have a 2+ year visa

Please provide a copy of birth certificate OR passport OR a 2+ year visa OR a gold card OR a CSC card

Which ethnic group do you belong to? (please circle)

NZ Maori

NZ European

Cook Island Maori

Niuean

Indian

Chinese

Tongan

Samoan

Other such as Dutch, Japanese, Tokelauan (please state)

Community Services Card / Gold Card

Card Number: _____

Valid From: _____

Expiry Date: _____

High User Health Card

Card Number: _____

Valid From: _____

Expiry Date: _____

Email: _____

Would you like to receive Practice Newsletters by email? Yes / No

Do you authorise for your results and recalls to be emailed to you? Yes / No

Your Occupation: _____

Next of KIN: _____ Their Phone Number: _____

Next of Kin's Relationship to you: Mother / Father / Brother / Sister / Son / Daughter / Partner
Friend / Husband / Wife / Other (circle one option)

Children under the age of 16, of whom I am the parent or guardian, to be enrolled at our practice:

Name	Ethnicity	DOB	NHI

Enrolment in the Practice/Primary Health Organisation (PHO)

I intend to use **Millhouse Integrative Medical Centre** as my regular and ongoing provider of general practice/GP/first level primary health care services.

I am entitled to enrol because **I am residing permanently in New Zealand** (intend to be resident in New Zealand for at least 183 days in the next 12 months) and meet **one** of the following criteria: *(please tick to indicate)*

a) I am a New Zealand Citizen	
b) I hold a resident visa or a permanent resident visa (or residence permit if issued before Dec 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	
h) I am 18 or 19 years old and can demonstrate that, on 15th April 2011, I was the dependent of an eligible work permit holder.	
i) 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).	
j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme.	
k) I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship Fellowship fund.	

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

My agreement to the enrolment process

NB Parent or caregiver to sign if you are under 16 years

I choose to enrol with this practice as my regular and ongoing provider of general practice/GP/first level primary health service

I understand that by enrolling with this practice I will be enrolled with the Primary Health Organisation (PHO) to which this practice belongs, and my name, address and other identification details will be included on both the Practice and the PHO enrolment register

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

I have been given information about the benefits and implications of enrolment with the PHO, and their contact details

I have read and agree with the Health Information Privacy Statement in the accompanying PHO information pamphlet

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

Your Name:	Date:	Signature:	
Children under the age of 16 of whom I am the parent or guardian to be enrolled at our practice			
Name:	Ethnicity	DOB:	NHI:

Or sign by authority

Name of Authority _____ Phone Number _____ Relationship _____

Address _____

Signature _____

Reason for signing on behalf of another person (eg under 6) _____

An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf

I authorise the transfer of my medical records from my previous GP to Millhouse Integrative Medical Centre		
YES / NO / NOT APPLICABLE	NHI:	Previous GP:
Your Name:		GP Address:
Your Signature:		GP Fax Number:

Millhouse Integrative Medical Centre – Medical Information Form

Please complete a medical information form for each patient

Patient Name _____ D.O.B _____

ARE YOU **ALLERGIC** TO ANY MEDICATIONS? NO or YES (if yes please state)

Do you have any of the following medical problems (please circle any that may apply to you)

Diabetes Heart Disease Asthma Joint Disease Arthritis Depression Anxiety
High Blood Pressure High Cholesterol Respiratory Disease Kidney Disease Liver Disease

Or any other medical problems not listed above: _____

Have you ever had any operations: NO / YES (please list): _____

Family Illness – are there any illnesses in your immediate family (see list above + cancers)

Father: _____

Mother: _____

Other family members: _____

If filling in this form for a child are their immunisations up to date? NO / YES / Imms declined

PATIENTS OVER 16:

Do you drink alcohol? NO / YES – if yes, how many drinks per week: _____ (#136..)

Do you exercise? Rarely / Moderate 2-3 times weekly / Everyday (#138..)

Do you smoke? Never smoked (#1371) / Current smoker(#137R) / Past smoker(#137S)

If past smoker when did you stop? _____

Females: When was your last smear? _____ Normal result: YES / NO

When was your last mammogram? _____ Normal result: YES / NO