

millhouse integrative medical centre



Enrolment for New and Existing Patients who intend to use
millhouse integrative medical centre
for most ongoing health care.

All pages of this form must be completed for enrolment with the
East Health Primary Health Organisation (PHO).

Surname: _____ First Name _____

Preferred Name _____ Title: Dr/Mr /Mrs/Miss/Ms/Master (Please circle)

Residential Address: _____

Work Phone number: _____ Home Phone: _____

Cell Phone: _____ Do you give authority for your results/recalls to be sent via text message? NO / YES

Date of Birth: _____ NHI number: _____

Name of Doctor with whom you wish to enrol at our clinic: _____

To which **ethnic** group do you belong? (circle option) NZ Maori / Cook Island Maori / NZ European /
Other European / Tongan / Niuean / Chinese / Indian / South East Asian / Asian / Fijian / Other _____

Are you a New Zealand Resident? YES / NO if not, Visa **1 year** or **2+ years** (circle one)
(please provide a copy of your Visa if it is valid for two or more years)

Do you have a Comm. Service / Gold / High Use Health card? No / Yes - card number _____

Do you give authority for your results and recalls to be emailed to you? NO / YES

Would you like to receive Practice Newsletters via email? NO / YES

Email: _____

Next of Kin: _____ Their Phone Number: _____

Next of Kin's relationship to you _____ Your Occupation _____

Children under age 16 (for whom you are the parent/guardian) to be enrolled at our practice:

Name: _____ Date of Birth _____ Male / Female (circle)

Name: _____ Date of Birth _____ Male / Female (circle)

Name: _____ Date of Birth _____ Male / Female (circle)

If enrolling with Millhouse Integrative Medical Centre as your PHO, please go to next page

Enrolment in the Practice/ Primary Health Organisation

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

I am eligible to enrol because **I live in New Zealand** and meet **one** of the following criteria:

- a) I am a New Zealand Citizen
- 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 apply 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 on 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; if signing on behalf **please fill out authority to sign below**

- ✓ I choose to enrol with this practice as my regular and ongoing provider of general practice/GP/first level primary health care services
- ✓ 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 enrolled, 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 I agree with the Health Information Privacy Statement
- ✓ I agree to inform the practice of any changes in my eligibility

Name of Patient and/or children under 16 to be enrolled at Millhouse Integrative Medical Centre PHO:

Your Name : _____ **DOB:** _____ **Signature:** _____

Children under 16 you are enrolling at **Millhouse Integrative Medical Centre**:

Name of Child _____ DOB _____

Name of Child _____ DOB _____

Name of Child _____ DOB _____

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

Full Name of authority _____ Address _____ Phone _____

Relationship _____ Reason for signing _____ Signature _____

Transfer of Records:	I authorise the transfer of my medical records from my previous GP to Millhouse Integrative Medical Centre YES / NO / NA	
Your Name:		
Previous Doctor Name:	Fax Number:	
Address:	Signature:	

Patient Name _____ D.O.B _____

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

Do you have any of the following medical problems? (please circle)

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 (refer list above + cancers)

Father: _____

Mother: _____

Other family members: _____

If filling this form for a child, are their immunisations up to date? NO / YES / Imms declined (circle)

PATIENTS OVER 16:

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

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

Do you exercise? Rarely (#1382) / Moderate 2-3 times weekly (#1384) / Every day (#1385)

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

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

Thank you for your assistance.

Office Use: Notes requested / NHI / Visa / PHO / Front Page

MEN: PSA / TD / CVDR WOMEN: TD / MAMM / CX / CVDR / CS

Patient Registered (Form Signed YES / NO) / **Casual** / **Visitor to NZ** **Visa sighted YES / NO**

PLEASE TICK AS COMPLETED