

PATIENT ENROLMENT FORM

Fields with * are compulsory		Anyone over age of 16 years must complete their own enrolment form			NHI (Office use only)	
Legal Name	Title	* Given Name	* Other Given Name	* Family Name		
Other Name(s) <small>(eg. maiden name)</small>		Preferred Name(s)				
Birth Details		* Day / Month / Year	* Place of Birth	* Country of birth		
Sex (at birth)	* <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender you would like to be identified as	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse			
Contact Details	<input type="checkbox"/> Work / <input type="checkbox"/> Home / <input type="checkbox"/> Mobile	<input type="checkbox"/> Work / <input type="checkbox"/> Home / <input type="checkbox"/> Mobile	Email Address			
Preferred Contact Method	<input type="checkbox"/> Patient Portal Email	<input type="checkbox"/> Text	Consent to use text messaging			
	<input type="checkbox"/> Landline	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Usual Residential Address	* House (or RAPID) Number & St		* Suburb/Rural Location	* Town / City & Postcode		
Postal Address <small>(if different from above)</small>	House Number & St Name or PO Box		Suburb/Rural Delivery	Town / City & Postcode		
Occupation and Employer						
Work Address	House Number & St Name or PO Box		Suburb/Rural Delivery	Town / City & Postcode		
Emergency Contact/NOK	Given Name		Family Name		Relationship	
Contact Details	<input type="checkbox"/> Work / <input type="checkbox"/> Home / <input type="checkbox"/> Mobile		<input type="checkbox"/> Work / <input type="checkbox"/> Home / <input type="checkbox"/> Mobile		Address	
Community Services Card	<input type="checkbox"/> Yes <input type="checkbox"/> No	Expiry Day / Month / Year		Card Number		
High User Health Card	<input type="checkbox"/> Yes <input type="checkbox"/> No	Expiry Day / Month / Year		Card Number		
* Ethnicity Details Which ethnic group(s) do you belong to? Tick the space or spaces which apply to you <input type="checkbox"/> New Zealand European <input type="checkbox"/> Maori Iwi _____ <input type="checkbox"/> Samoan <input type="checkbox"/> Cook Island Maori <input type="checkbox"/> Tongan <input type="checkbox"/> Niuean <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan) Please state <div style="border: 1px solid black; height: 20px; width: 100%;"></div>				Smoking is an important factor influencing health If you are aged 15 and over please tick the space that applies for you <input type="checkbox"/> Currently smoke <input type="checkbox"/> Recently quit <input type="checkbox"/> Ex-smoker (over 1 year) <input type="checkbox"/> Never smoked Smoking is hugely negative on your good health. In most cases, you will experience the benefits of quitting immediately. If you currently smoke, would you like some help to quit? <div style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div>		

How did you hear about us? (ie. Friends, Facebook, Google, Radio, Hamilton Maps) _____

* My declaration of entitlement and eligibility

I am entitled to enrol because I am residing permanently in New Zealand. <i>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>	<input type="checkbox"/>
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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)	<input type="checkbox"/>
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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)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>

I confirm that, if requested, I can provide proof of my eligibility	<input type="checkbox"/>	Evidence sighted (<i>Office use only</i>)
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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 NORTH CARE MEDICAL CENTRES I will be included in the enrolled population of Pinnacle Midlands Health Network Charitable Trust 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 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 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	<input type="checkbox"/>	<input type="checkbox"/>
			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 <i>(where signatory is not the enrolling person)</i>	Full Name	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age)		



Dr A Lad
Dr F Hamilton
Dr R Doran
Dr A Loh
Dr V Jandhyala

10b Pukete Road
HAMILTON 3200
NEW ZEALAND
Phone: 07 850 9900
Fax: 07 849 4871

Website: www.northcare.co.nz

Patient History

Name: _____

Date of Birth: _____

PERSONAL MEDICAL HISTORY:

Epilepsy	Yes/No	Liver Disease	Yes/No	Asthma	Yes/No
Migraines	Yes/No	Headaches	Yes/No	Hypertension	Yes/No
Diabetes	Yes/No	Blood Clots	Yes/No	Varicose Veins	Yes/No

For women: Any abnormal cervical smear history Yes/No

Smoker? Yes/No If yes, how many per day? _____
Drink Alcohol? Yes/No If yes, what type, how often and how many
standard drinks do you consume per day/week?

Previous Surgery Yes/No If yes, what for and when? _____

Regular Medications: _____

Do you suffer from any allergies? _____

Any other relevant history: _____

Family History:

Heart Disease	Yes/No	Cancer	Yes/No	Osteoporosis	Yes/No
Stroke	Yes/No	Diabetes	Yes/No	Asthma	Yes/No
Blood Clots	Yes/No	Hypertension	Yes/No		

If yes to any of the above, please provide details: _____

Signed: _____ Date: _____

**Thank you for taking the time to complete this form.
It will enable the Doctors to give you the best possible care.**

NorthCare
10B Pukete Road
Te Rapa 3200
 Northcare EDI: hamnormc

Doctors **NZMC**

Dr Amrat Lad 16954
 Dr Fraser Hamilton 21293
 Dr Vidya Jandhyala 45773

Doctors **NZMC**

Dr Rebekah Doran 42208
 Dr Alicia Loh 62091

REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

Each person 16 years or over to complete and sign own form

In order to receive the best care possible, I agree to **NorthCare** obtaining my medical records from my previous doctor. I also understand that I will be removed from their practice register.

To: [name of previous doctor]

Address:

Please transfer the medical records for the following people to **NorthCare**

Family Name	Given Names	DOB	NHI	Gender	ETH

**Our practice is able to receive and would prefer electronic GP2GP notes transfer.
 Our EDI is hamnormc.**

Signed: _____

Date: _____



Pukete Road

10B Pukete Road, Pukete, Hamilton

Ph: 07 850 9900 Fax: 07 849 4871

Website: www.northcare.co.nz

INFORMATION SHEET



Doctors at Pukete Road:

Fraser Hamilton
Amrat Lad
Vidya Jandhyala
Alicia Loh
Rebekah Doran

Clinical Pharmacist

Penny Clark

Operations Manager:

David Gaines



OPENING HOURS

Monday, Wednesday, Thursday
8am-5pm

Tuesday, Friday
7am -5 pm

Closed weekends and statutory holidays

**For After Hours Service please phone
07 850 9900 – Your call will be triaged
by Registered Nurses**

SERVICES AVAILABLE AT NORTHCARE:

Family & General Practice
Medical Emergencies
Accident Care
Well Health Checks
Employment Medicals
Insurance Medicals
Dive Medicals
Driving Medicals
Diabetic Checks
Asthma Checks
Cervical Smears

Childhood Immunisations
Travel Vaccinations
Vasectomies
Weight Loss Management
Spirometry & Audiometry
ECGs
Blood Pressure Checks



OTHER SERVICES

Ear Health's trained NZ registered Nurse every **Wednesday** can provide ear micro – examination/micro-suction (using microscope) for clear healthy ears
Freephone 0800 777 327 to book an appointment

FEES: Please see our current fee structure which is displayed in our waiting rooms. Fees are payable at the time of consultation. We also accept direct credit, automatic payments and you can also pay online via our website: using Paymark.

TEST RESULTS: You will only generally be rung and advised of abnormal test results but you can phone us for a nurse to contact you with any results of tests you have had.

MY INDICI: Please read the attached leaflet about this confidential service available to you online. You can access your test results/consultation notes, long term medications and also email your doctor directly to prescription requests.

Code of Health and Disability Services Consumers' Rights: In providing a quality health service this practice complies with the code of rights. If you feel your rights have been breached, please let us know, we welcome any opportunity to improve our standards of service. You can add a comment to our suggestion box, make a complaint verbally or in writing, or phone the Health and Disability Commissioners office on 0800 11 22 33 to be supported by one of their advocates.

Our friendly staff are always available to answer any questions you may have ☺

***We are part of the Midlands Health Network
for the Waikato Region***