NorthCare

☐ NorthCare, 10B Pukete Rd, Hamilton Ph. 07 850 9900
☐ NorthCare, 107 Grandview Rd, Hamilton Ph. 07 847 2168
☐ NorthCare, 107 Thomas Rd, Hamilton Ph. 07 853 6130

Pinnacle Midlands Health Network

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) (eg. maiden name)			**Preferred Name(s)**	
Birth Details		* Day / Month / Year	* Place of Birth	* Country of birth
Sex (at birth)		* ☐ Male ☐ Female	**Gender** you would like to be identified as	☐ Male ☐ Female ☐ Gender Diverse _____
Contact Details	☐Work / ☐Home / ☐Mobile	☐Work / ☐Home / ☐Mobile	Email Address	
Preferred Contact Method	☐ Patient Portal Email ☐ Text ☐ Landline ☐ Cell Phone		Consent to use text messaging ☐ Yes ☐ No	

Usual Residential Address	* House (or RAPID) Number & St	* Suburb/Rural Location	* Town / City & Postcode
Postal Address (if different from above)	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	☐Work / ☐Home / ☐Mobile	☐Work / ☐Home / ☐Mobile	Address

Community Services Card	☐ Yes	☐ No	Expiry Day / Month / Year	Card Number
High User Health Card	☐ Yes	☐ 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

☐ **New Zealand European**

☐ **Maori**
Iwi _____

☐ **Samoan** ☐ **Cook Island Maori**

☐ **Tongan** ☐ **Niuean**

☐ **Chinese** ☐ **Indian**

☐ **Other** (such as Dutch, Japanese, Tokelauan)
Please state

Smoking is an important factor influencing health
If you are aged 15 and over please tick the space that applies for you

☐ Currently smoke
☐ Recently quit
☐ Ex-smoker (over 1 year)
☐ 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?

☐ Yes ☐ No

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. *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 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)	☐
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 NORTHCARE 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**	☐ **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)		

NorthCare
Thomas Road

107 Thomas Road, Rototuna, Hamilton
Ph: 07 853 6130 *Fax:* 07 853 6131
Website: www.northcare.co.nz

Dr M Raza ; Dr H Cooray ; Dr J Morgan

PATIENT HISTORY

Name: _____

Date of Birth: _____

Personal Medical History:
(Please Circle below)

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
About _____ drinks 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 give 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
107 Thomas Road
Hamilton 3210
Northcare EDI: hamnormc

Doctors	NZMC
Dr John Morgan	19027
Dr Madiha Raza	48173
Hashira Cooray	42539

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

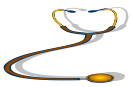
Signed: _____ **Date:** _____

NorthCare

Thomas Road

107 Thomas Road, Rototuna, Hamilton
Ph: 07 853 6130 *Fax:* 07 853 6131
Website: www.itsmyhealth.co.nz

INFORMATION SHEET



Doctors at Thomas Road:
Hashira Cooray
John Morgan
Madiha Raza

Operations Manager:
David Gaines

OPENING HOURS

Monday – Friday
8.00 am - 5 pm

Please Note:
Once a month clinics do not open until **9am** on Tuesday due to a staff meeting

Closed weekends and statutory holidays

For After hours Service please Use Anglesea Clinic Accident and Medical 858 0800

SERVICES AVAILABLE AT NORTHCARE:

Family & General Practice
Medical Emergencies
Accident Care
Well Health Checks
Insurance Medicals
Driving Medicals
Diabetic Checks
Asthma Checks
Cervical Smears
Childhood Immunisations
Travel Vaccinations
Weight Loss Management
ECGs
Blood Pressure Checks

OTHER SERVICES

Clinical Pharmacist
Primary Mental Health Coordinator
WorkWise

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: (Patient Portal) Access your health information Via online with your computer, smartphone or device. Check your test results/consultation notes, long term medications, make appointments and also email your doctor directly for prescription requests or advice.

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