Lake Surgery
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 (please state)	
Occupation			**Employer** Name, address and phone number	

Usual Residential Address	* House (or RAPID) Number & Street	* 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

Contact Details	Work Phone	Mobile Phone	Home Phone	Email Address
Emergency Contact/NOK	Name	Relationship		Phone and/or Mobile

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***	☐ 11 **New Zealand European** ☐ 21 **Maori** Iwi _____ ☐ 31 **Samoan** ☐ 32 **Cook Island Maori** ☐ 33 **Tongan** ☐ 34 **Niuean** ☐ 42 **Chinese** ☐ 43 **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
Primary Language	☐ English ☐ Other (please state): _____	**Do you require an interpreter?** ☐ Yes ☐ No

* 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

Parent or Caregiver to sign as Authority 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 Lake Surgery I will be included in the enrolled population of Midlands Regional 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)		

The Lake Surgery Ltd
109 Tongariro Street Taupo 3330
P O Box 53 Taupo 3351
Phone: 07 378 6294
Fax: 07 378 6515
www.lakesurgery.co.nz

Name:		Date of Birth:	

Condition	Self	Family	Comments
Asthma	Yes / No	Yes / No	
Other long term respiratory problems	Yes / No	Yes / No	Please specify:
Blood clot	Yes / No	Yes / No	
Cancer	Yes / No	Yes / No	Please specify:
Diabetes	Yes / No	Yes / No	Type 1 or type 2?
Epilepsy	Yes / No		
Hearing or eye problems	Yes / No	Yes / No	Please specify:
Heart disease	Yes / No	Yes / No	Please specify: Age of onset:
High blood pressure	Yes / No	Yes / No	
High cholesterol	Yes / No	Yes / No	
Mental health issues e.g. depression or anxiety	Yes / No	Yes / No	
Other long term conditions, e.g. kidney, liver, or bowel disease	Yes / No	Yes / No	Please specify:
Rheumatic fever	Yes / No	Yes / No	
Stroke	Yes / No	Yes / No	Age of onset:
Tuberculosis (TB)	Yes / No	Yes / No	

Do you have any other health or disability problems or inherited conditions? (please list)				
Please list any regular medications you take:				
Have you ever been admitted to hospital or had any operations? (please list)				
Do you have any allergies? Please give details:				
Do you smoke?	O Current smoker:	Quitting smoking is one of the best things you can do for your health. Would you like help to quit?	O Yes	O No
	O Past smoker:	When did you give up smoking?		
	O Never smoked			
Do you drink alcohol?	O Yes O No	If yes – how many drinks per week?		
When was your last tetanus booster?				
Are your childhood immunisations up to date?	O Don't know		O Yes	O No

This section is for women only:				
Have you had a hysterectomy?	O Yes O No	Details:		
Cervical smear:	Date of last cervical smear: Have you ever had an abnormal smear?	O Don't know	O Yes	O No
Mammogram: (if aged 45 to 69 years)	Date of last mammogram: Would you like us to enrol you in the Breast Screening Programme?	O Already enrolled	O Yes	O No

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REQUEST FOR MEDICAL RECORDS TRANSFER

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

I agree to Lake Surgery obtaining my medical records from my previous doctor. I also understand that I will be removed from my previous practice's register.

Name of previous doctor or practice:

Address:

Please transfer the medical records for the following person to Lake Surgery:

Family Name	Given Names	DOB or NHI

Signed: _____ Date: _____

For transferring practice:

Please send electronic notes via GP2GP along with any hard file records

EDI: *lakesurg* Lake Surgery NZMC# 99999

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