

|  |                   |  |  |
|--|-------------------|--|--|
|  | ENROLMENT<br>FORM |  <b>Cornwall<br/>Medical<br/>Centre</b> | 790 Manukau Rd<br>P O Box 24-401<br>Royal Oak<br>Ph 09 625 3140<br>www.cornwallmedical.co.nz |
|--|-------------------|--|--|

|                                     |  |                       |
|-------------------------------------|--|-----------------------|
| <b>Fields shaded are compulsory</b> |  | NHI (Office use only) |
|-------------------------------------|--|-----------------------|

|   |                          |   |                                      |  |   |
|---|--------------------------|---|--------------------------------------|--|---|
| <b>Name</b>   |                          | Given Name  | Middle name/Other Given Name(s)      | Family Name  |   |
|   | (Title)                  |   |                                      |  |   |
| <b>Preferred Name</b>   |                          | <b>Other Names (eg. Maiden name)</b>  |                                      |  |   |
| <b>Birth Details</b>  |                          | Day / Month / Year of Birth   | Place of Birth                       | Country of birth   |   |
| <b>Gender</b>   | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/>             | Occupation   |   |
|   | Male                     | Female  | Gender diverse (please state)        |  |   |
| <b>Usual Residential Address</b>  |                          | House (or RAPID) Number and Street Name   | Suburb/Rural Location                | Town / City and Postcode                                 |   |
| <b>Postal Address</b><br><small>(if different from above)</small>   |                          | House Number and Street Name or PO Box Number   | Suburb/Rural Delivery                | Town / City and Postcode                                 |   |
| <b>Contact Details</b>  |                          | Mobile Phone  | Home Phone                           | Email Address  |   |
| <b>Emergency Contact</b>  |                          | Name  | Relationship                         | Mobile (or other) Phone                                  |   |
| <b>Transfer of Records</b>  |                          | <i>In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register.</i> |                                      |  |   |
|   |                          | <input type="checkbox"/> Yes, please request transfer of my records   | <input type="checkbox"/> No transfer | <input type="checkbox"/> Not applicable                  |   |
|   |                          | Previous Doctor and/or Practice Name  | Address / Location                   |  |   |
|   |                          | Signature   |                                      |  |   |
|   |                          | <b>Do you agree to receive text messages?</b>   |                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| <b>Ethnicity Details</b><br><small>Which ethnic group(s) do you belong to?<br/>Tick the space or spaces which apply to you</small>  |                          | <b>Community Services Card</b>  |                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| <input type="radio"/> New Zealand European<br><input type="radio"/> Maori*<br><input type="radio"/> Samoan<br><input type="radio"/> Cook Island Maori<br><input type="radio"/> Tongan<br><input type="radio"/> Niuean<br><input type="radio"/> Chinese<br><input type="radio"/> Indian<br><input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state<br><input style="width: 100%; height: 20px;" type="text"/><br><small>* Iwi (if known)</small><br><input style="width: 100%; height: 20px;" type="text"/> |                          | Day / Month / Year of Expiry  | Card Number                          |  |   |
|   |                          | <b>High User Health Card</b>  |                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |
|   |                          | Day / Month / Year of Expiry  | Card Number                          |  |   |
|   |                          | <b>Do you Smoke?</b>  |                                      | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No (ex-smoker) |
|   |                          | <b>I wish to enrol with Dr</b> <input style="width: 150px; height: 25px;" type="text"/>   |                                      |  |   |
|   |                          | <b>An Lim, Carmel Built, Patricia Reeves, Peter Zink, Steven Tan, Vincent Chan,<br/>Wee Ling Khoo</b>   |                                      |  |   |

## 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)  | <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 <b>OR</b> 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

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 this practice, I will be included in the enrolled population with the Primary Health Organisation (PHO) this practice belongs to, 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.

|                          |           |                    |                          |                          |
|--------------------------|-----------|--------------------|--------------------------|--------------------------|
| <b>Signatory Details</b> | 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.**

|  |   |              |               |
|--|---|--------------|---------------|
| <b>Authority Details</b><br><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) |              |               |

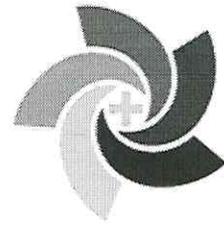
**PLEASE TURN OVER AND COMPLETE THE REVERSE**

Cornwall Medical Centre

790 Manukau Road, Royal Oak, Auckland 1023

P O Box 24 401, Royal Oak, Auckland 1345

Ph 09 625 3140 Fax 09 625 3142



**Cornwall  
Medical  
Centre**

Healthlink: cornwall

---

**Request for Notes from another Surgery**

Date \_\_\_\_\_

I/We request that my/our medical records are transferred to

Dr \_\_\_\_\_ at Cornwall Medical Centre

Name

D.O.B.

NHI

Signature

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Notes requested from previous Dr \_\_\_\_\_

Name of previous Doctor's Surgery \_\_\_\_\_

Address of previous Surgery \_\_\_\_\_

Fax Number \_\_\_\_\_ Phone Number \_\_\_\_\_

**Electronic Notes Transfer: GP2GP Capable**

|              |                    |       |
|--------------|--------------------|-------|
| NZMC Numbers | Dr An Lim          | 51418 |
|              | Dr Carmel Built    | 12944 |
|              | Dr Patricia Reeves | 60780 |
|              | Dr Peter Zink      | 13122 |
|              | Dr Steven Tan      | 38474 |
|              | Dr Vincent Chan    | 38152 |
|              | Dr Wee Ling Khoo   | 14117 |

*(To be completed by your previous Dr's Practice Manager)*

**Are there any outstanding monies owed to your practice by this patient? Yes/No**

Please complete one form for each member of your family over 16yrs and hand back to reception

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

1. Do you have any, or have had any of the following medical problems?, or is there a family history of the following:

|   | Self                         | Family                       |                   | Self                         | Family                       |
|---|------------------------------|------------------------------|-------------------|------------------------------|------------------------------|
| Diabetes  | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | Blood clot        | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| High blood pressure                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | Stroke            | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| Heart disease or problems                           | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | High cholesterol  | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| Heart Attack <60yr<br>>60yr                         | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | Migraine          | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| Asthma  | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | Epilepsy          | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| Other lung or respiratory disease or problems       | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | Breast cancer     | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| Kidney disease or problems                          | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | Other cancer      | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| Liver disease or Hepatitis                          | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | Glaucoma          | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| Bowel disease or problems                           | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | Rheumatic Fever   | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| Joint disease or problems, arthritis                | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | Tuberculosis (TB) | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| Depression and/or anxiety                           | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | Eczema            | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| Other mental health illnesses                       | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | Hay Fever         | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| <b>Brief details please if you have ticked yes:</b> |                              |                              |                   |                              |                              |

2. Do you have any **other health, disability problems or inherited conditions?** – please list

3. Please list any **regular medications** that you take

4. Have you had any **operations?**  Yes  No *If yes, please list*

5. Are you **allergic** to any medications?  Yes  No *If yes, please list*

6. Do you **smoke?**  No  Yes *If yes, how many / day \_\_\_\_\_*  
 If Yes - would you like help to **quit smoking**  Yes  No

Have you ever smoked  No  Yes *If yes, how much and for how long \_\_\_\_\_*  
 when did you give up \_\_\_\_\_

7. Do you drink **alcohol?**  No  Yes *If yes, on average, how much / week \_\_\_\_\_*  
 and what type \_\_\_\_\_

8. Do you have any **substance abuse** problems?  Yes  No

9. **Women:** (those over 20 years)  
 When was your most recent cervical smear? \_\_\_\_\_  
 Have you ever had an abnormal smear?  Yes  No  Don't know  
 Have you had a mammogram (those over 40 years)?  No  Yes *If Yes, when? \_\_\_\_\_*

10. When was your last **Tetanus booster?** \_\_\_\_\_

11. Are your **childhood immunisations** up to date?  Yes  No  Don't know

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*If you enrolled and requested your medical notes to be transferred from your previous GP we wish to advise you that we will hold these securely for reference only. The notes will not be specifically reviewed unless you request us to, or unless the Doctor feels that your medical history warrants this. Please be careful to disclose all important medical/surgical/psychiatric information.*

## Health Information Privacy Statement

It is compulsory for general practices to ask you to read and agree to this statement before signing the enrolment form. Once you have read it, please tick the corresponding box on your enrolment form and sign it.

### I understand the following:

#### Access to my health information

I have the right to access (and have corrected) my health information under Rules 6 and 7 of the Health Information Privacy Code 1994.

#### Visiting another GP

If I visit another GP who is not my regular doctor I will be asked for permission to share information from the visit with my regular doctor or practice.

If I have a High User Health Card or Community Services Card and I visit another GP who is not my regular doctor, he/she can make a claim for a subsidy, and the practice I am enrolled in will be informed of the date of that visit. The name of the practice I visited and the reason(s) for the visit will not be disclosed unless I give my consent.

#### Patient enrolment information (enrolled patients only)

The information I have provided on the Practice enrolment form will be:

- held by the practice
- used by the Ministry of Health to give me a National Health Index (NHI) number, or update any changes
- sent to the PHO and Ministry of Health to obtain subsidised funding on my behalf
- 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.

#### Health information

Members of my health team may:

- add to my health record during any services provided to me and use that information to provide appropriate care
- send relevant health information to other health professionals who are directly involved in my care.

#### Audit

In the case of financial audits, my health information may be reviewed by an auditor for checking a financial claim made by the practice, but only according to the terms and conditions of section 22G of the Health Act (or any subsequent applicable Act). I may be contacted by the auditor to check that services have been received. If the audit involves checking on health matters, an appropriately qualified health care practitioner will view the health records.

#### Health programmes

Health data relevant to a programme in which I am enrolled (e.g., breast screening, immunisation, diabetes) may be sent to the PHO or the external health agency managing this programme.

#### Other uses of health information

Health information which will not include my name but may include my National Health Index Identifier (NHI) may be used by health agencies such as the district health board, Ministry of Health or PHO for the following purposes, as long as it is not used or published in a way that can identify me:

- health service planning and reporting
- monitoring service quality
- payment.

#### Research

My health information may be used for health research, but only if this has been approved by an Ethics Committee and will not be used or published in a way that can identify me.

Except as listed above, I understand that details about my health status or the services I have received will remain confidential within the medical practice unless I give specific consent for them to be communicated.

**Please turn overleaf for further information**

## How do I enrol?

To enrol you must be eligible and complete the accompanying enrolment form at the general practice of your choice.

### What are the enrolment criteria?

To enrol as a permanent patient, you must meet one of the eligibility criteria listed below.

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

- a. I am a New Zealand citizen **OR**
- b. I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) **OR**
- 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 **OR**
- 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) **OR**
- e. I am an interim visa holder\*\* who is eligible immediately before my interim visa started **OR**
- 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 **OR**
- 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**
- h. I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder **OR**
- 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) **OR**
- j. I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme **OR**
- k. 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.

These eligibility criteria are repeated on your enrolment form and you will be asked to tick the one that applies to you.

For further information about eligibility please refer to [www.moh.govt.nz/eligibility](http://www.moh.govt.nz/eligibility).

## Other situations where you may be asked to sign an enrolment form:

### Casual patient

If you do not meet the enrolment criteria and wish to be a casual patient, please complete the relevant parts of the enrolment form.

### Enrolling children (under 16 years)

Parents can enrol and sign for children under 16 years of age, but children 16 years or over must sign their own form.

### Enrolling on someone else's behalf (other than children)

In some circumstances you may sign for another person if for some reason they are unable to consent on their own behalf. This is referred to as Signed by Authority.

An Authority is the legal right to sign for another person.

### FAQs:

#### What happens if I go to another general practice?

You can go to another general practice or change to a new general practice at any time. If you are enrolled in a PHO through one general practice and visit another practice as a casual patient you will pay a higher fee for that visit. So if you have more than one general practice you should consider enrolling with the practice you visit most often.

#### What happens if the general practice changes to a new PHO?

If the general practice changes to a new PHO the practice will make this information available to you.

#### What happens if I am enrolled in a general practice but don't see them very often?

If you have not received services from your general practice in a three-year period it is likely that the practice will contact you and ask if you wish to remain with the practice. If you are not able to be contacted or do not respond, your name will be taken off the Practice and PHO Enrolment Registers. You can re-enrol with the same general practice or another general practice and the affiliated PHO at a later time.

\*The definition of residing in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months.

\*\*If a person has an interim visa this means they are waiting for Immigration to finish processing an application (as Immigration issues an interim visa if the old visa has run out but the new visa is still being processed). For example, a person may have had a two year work permit and has been issued with an interim visa while waiting for their application for another two year work permit to be processed. Immigration usually issue interim visas in a letter form.

\*\*\* Funded by NZAID or ODA programme or funded by NZ Universities as a Commonwealth Scholarship holder.