

ENROLMENT FORM



790 Manukau Rd
P O Box 24-401
Royal Oak
Ph 09 625 3140
www.cornwallmedical.co.nz

Fields shaded are compulsory

Anyone over the age of 16 years old must complete their own enrolment form

NHI (Office use only)

Name	(Title)	Given Name	Middle name/Other Given Name(s)	Family Name
Preferred Name			Other Names (e.g. Maiden name)	
Birth Details	Day / Month / Year of Birth		Place of Birth	Country of birth
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)	Occupation
Usual Residential Address	House (or RAPID) Number and Street Name		Suburb/Rural Location	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number		Suburb/Rural Delivery	Town / City and Postcode
Contact Details	Mobile Phone	Home or Work Phone <i>(Please specify)</i>	Email Address	
Emergency Contact	Name		Relationship	Mobile (or other) Phone
Transfer of Records	<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			
Ethnicity Details Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	<input type="checkbox"/> New Zealand European <input type="checkbox"/> Maori Iwi: _____ Hapū: _____ <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 Other (such as Dutch, Japanese, Tokelauan). Please state _____		Do you agree to receive text messages?	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Would you like us to register you for our online portal Manage My Health?	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Community Services Card	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Day / Month / Year of Expiry		Card Number	
	High User Health Card		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Day / Month / Year of Expiry		Card Number	
	Do you Smoke?		<input type="checkbox"/> Yes	<input type="checkbox"/> No (ex-smoker) <input type="checkbox"/> Never
	I wish to enrol with		Dr Vincent Chan	

Primary Health Services Provider Enrolment Form

PLEASE TURN OVER AND COMPLETE THE REVERSE

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 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

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.

Signatory Details	Signature	Day / Month / Year	<input type="checkbox"/> Self-Signing	<input type="checkbox"/> Authority
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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)		

PLEASE TURN OVER AND COMPLETE THE REVERSE

reception@cornwallmedical.co.nz

790 Manukau Road, Royal Oak, Auckland 1023

P O Box 24 401, Royal Oak, Auckland 1345

Ph 09 625 3140

HealthLink: cornwall



**Cornwall
Medical
Centre**

reception@cornwallmedical.co.nz

Request for Notes from previous medical centre

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 _____

Email address _____

Phone Number _____

Electronic Notes Transfer: GP2GP Capable

NZMC Numbers	Dr An Lim	51418
	Dr Bethany Eames	72659
	Dr Peter Zink	13122
	Dr Steven Tan	38474
	Dr Vincent Chan	38152
	Dr Wee Ling Khoo	14117
	Dr Jacqueline Tam	18165
	Dr Ker Liong	58344
	Dr Olivia Mackay	86681

(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

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 >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

Brief details please if you have ticked yes:

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.

Please be aware that we are required to sight your proof of eligibility and identity before we can process your enrolment with us.

This can be (but is not limited to) a:

- NZ passport
- Foreign passport AND eligible visa
- NZ birth certificate AND photo ID
- Australian Passport AND proof of NZ address

For Children and young adults, we can accept: A NZ birth certificate, NZ passport or a foreign passport WITH (eligible) visa.