# PATIENT ENROLMENT FORM

ProCare

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

- Dr An Lim (51418)
- Dr Bethany Eames (72659)
- Dr Jacqueline Tam (18165)
- Dr Ker Liong (58344)
- Dr Steven Tan (38474)
- Dr Manu Siriwerdena (60552)
- Dr Vincent Chan (38152)
- Dr Wee Ling Khoo (14117)
- Dr Thilanka Weerasooriya (68510)

**edi: cornwall**

| Fields with * are compulsory | *Anyone over age of 16 years must complete their own enrolment form* | NHI (*Office use only*) |
|---|---|---|

| | | | |
|---|---|---|---|
| **Name** Title | * Given Name | * Other Given Name(s) | * Family Name |
| **Preferred Name** | | **Other names** (eg. maiden name) | |
| **Birth Details** | * Day / Month / Year of Birth | * Place of Birth | * Country of birth |
| **Gender** | * ☐ Male ☐ Female ☐ 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 Phone | Email Address | |
| **Emergency Contact** | Name | Relationship | Mobile (or other) Phone |
| **Transfer of Records** | *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.* | | |
| | ☐ Yes, please request transfer of my records | ☐ No transfer | ☐ Not applicable |
| | Previous Doctor and/or Practice Name | Signature | |
| | **Do you agree to receive text messages?** | ☐ Yes | ☐ No |
| | **Would you like us to register you for our online portal Manage My Health?** | ☐ Yes | ☐ No |

**Ethnicity Details**
Which ethnic group(s) do you belong to?
**Tick the space or spaces which apply to you**

- ○ NZ European
- ○ Māori

Iwi: _____
Hapū: _____

- ○ Samoan
- ○ Cook Island Māori
- ○ Tongan
- ○ Niuean
- ○ Chinese
- ○ Indian
- ○ Other (such as Dutch, Japanese, Tokelauan). Please state

_____

| | | | |
|---|---|---|---|
| Community Services Card | ☐ Yes | ☐ No | |
| Day / Month / Year of Expiry | Card Number | | |
| High User Health Card | ☐ Yes | ☐ No | |
| Day / Month / Year of Expiry | Card Number | | |
| Do you Smoke? | ☐ Yes | ☐ No (ex-smoker) | ☐ Never |
| Disabilities: | | | |
| Comments: | | | |

**I wish to enrol with Dr**

Ker Liong (Dr An Lim)

**Dr An Lim, Dr Bethany Eames, Dr Jacqueline Tam, Dr Ker Liong, Dr Manu Siriwerdena, Dr Steven Tan, Dr Thilanka Weerasooriya, Dr Vincent Chan, Dr Wee Ling Khoo**

**PLEASE TURN OVER TO COMPLETE MANDATORY INFORMATION**

## * My declaration of entitlement and eligibility *

| | |
|---|---|
| I am entitled to enrol because I am residing permanently in New Zealand.<br>*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 <u>not</u> 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 this practice I will be included in the enrolled population of the Primary Health Organisation 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 | ☐ *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<br>*(where signatory is not the enrolling person)* | *Full Name* | *Relationship* | *Contact Phone* |
| Authority Details | *Basis of authority (e.g., parent of a child under 16 years of age)* | | |

reception@cornwallmedical.co.nz
790 Manukau Road, Royal Oak, Auckland 1023
P O Box 24 401, Royal Oak, Auckland 1345
Ph 09 625 3140
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**HealthLink: cornwall**

Cornwall Medical Centre

# 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** **edi:cornwall**

| NZMC Numbers | | |
|---|---|---|
| | Dr An Lim | 51418 |
| | Dr Bethany Eames | 72659 |
| | Dr Jacqui Tam | 18165 |
| | Dr Thilanka Weerasooriya | 68510 |
| | Dr Manu Siriwardena | 60552 |
| | Dr Steven Tan | 38474 |
| | Dr Vincent Chan | 38152 |
| | Dr Wee Ling Khoo | 14117 |
| | Dr Ker Liong | 58344 |

**PLEASE NOTE: WE DO NOT ACCEPT PHYSICAL NOTES, PLEASE PASS ON ALL PHYSICAL NOTES DIRECTLY TO THE PATIENT**

(To be completed by your previous Dr's Practice Manager)
**Are there any outstanding monies owed to your practice by this patient?** Yes/No

**Cornwall Medical Centre**
Please complete one form for each member of your family over 16yrs

**New Patient Medical Questionnaire**

**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 | ☐ Yes | ☐ Yes | Blood clot | ☐ Yes | ☐ Yes |
| High blood pressure | ☐ Yes | ☐ Yes | Stroke | ☐ Yes | ☐ Yes |
| Heart disease or problems | ☐ Yes | ☐ Yes | High cholesterol | ☐ Yes | ☐ Yes |
| Heart Attack <60yr >60yr | ☐ Yes | ☐ Yes | Migraine | ☐ Yes | ☐ Yes |
| Asthma | ☐ Yes | ☐ Yes | Epilepsy | ☐ Yes | ☐ Yes |
| Other lung or respiratory disease or problems | ☐ Yes | ☐ Yes | Breast cancer | ☐ Yes | ☐ Yes |
| Kidney disease or problems | ☐ Yes | ☐ Yes | Other cancer | ☐ Yes | ☐ Yes |
| Liver disease or Hepatitis | ☐ Yes | ☐ Yes | Glaucoma | ☐ Yes | ☐ Yes |
| Bowel disease or problems | ☐ Yes | ☐ Yes | Rheumatic Fever | ☐ Yes | ☐ Yes |
| Joint disease or problems, arthritis | ☐ Yes | ☐ Yes | Tuberculosis (TB) | ☐ Yes | ☐ Yes |
| Depression and/or anxiety | ☐ Yes | ☐ Yes | Eczema | ☐ Yes | ☐ Yes |
| Other mental health illnesses | ☐ Yes | ☐ Yes | Hay Fever | ☐ Yes | ☐ 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 (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.*