

**NEW PATIENT - ENROLMENT FORM** 

**ENROLMENT FORM**

**Fields marked with \* are compulsory**

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| --- | --- | --- | --- | --- |
| **Legal Name\*** | (Title) | **Family Name**  | **First Name(s)** | **Middle Name(s)** |
|  |  |  |  |
| **Other Name(s)** Eg: Maiden Name/Preferred Name)Please tick the name you prefer to be known as |  | **NHI****(office Use only)** |  | **I.D:** | **Photo I.D. sighted ****Address Verified** **** |
|  |  |
| **Birth Details\*** |  **Day/Month/Year of Birth\*** | **Place of Birth\*** | **Country of Birth\*** |
|  |  |  |
| **Gender\*** |  |  |  **Gender diverse (please state)** |  **Student ID No:**  |
| **Male** |  **Female** | **Gender Assigned at Birth: F/M****Preferred Gender you Identify as:** |
| **During Academic****Year. 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** |

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| --- | --- | --- | --- |
| **Contact Details** |  |  | I agree to receiving Txt messages Yes ****No****  |
|  |
|  **Mobile Phone** |  **Home Phone** | Email Address |
| **Emergency Contact/NOK** |  |  |  |
| Name | Relationship | Mobile (or other) Phone |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 |
| **NZAID Student**  | ******Yes** | ******No** | **Permanent Resident** | Yes **** No **** | **Allergies:** to medication please specify. |

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| **Ethnicity Details** |
|  Which ethnic group(s) do you belong to? (Tick multiple boxes if needed, including Iwi.) New Zealand European Maori Samoan Cook Island Maori Tongan Niuean Chinese Indian Other (such as Dutch, Japanese, Tokelauan). Please state:**Iwi** |

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| --- | --- | --- | --- |
| **Smoking Status:** | Smoker **** | Never Smoked **** | Ex-Smoker ****No. years since quit   |
| **Cervical Screening** **Status: Normal ****Date:**  | **Previous Abnormal:****Date:** | **HPV Vaccine:**  Yes **** No ******Date:**  |

Consent to Share Health Information with other Health Providers involved in my care:

 Yes **** No ****

**FREE PATIENT PORTAL**

****My Indici is an online portal service where you can access your health information, interact with the clinic and can book appointments and can request repeat scripts for free of cost.

Signup with portal: Yes **** No ****

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| **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** |

**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 the ***Student Health Service*.** I will be included in the enrolled population of the Pinnacle Midlands Health Network 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 Understand** that while enrolled as a Student at UOW I will be charged the Standard Fee that is subsidised for students

**I Understand** that if I choose to remain enrolled with Student Health after my studies (We encourage you to find a local Doctor) I will be charged regular GP fees and will not have access to Counselling and Mental Health Nurses

**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 |
|  |  |  |  |

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**REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED**

**In order to receive the best care possible, I agree to Student Health Service, University of Waikato obtaining my medical records from my previous doctor. I also understand that I will be removed from their practice register.**

Name of previous medical practice/ doctor:

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

**Full Name: ……………………………………………………………………………**

**DOB: …………………………. or NHI number: ……………………….**

**Signature: ……………………………… Date: ……………………..**

**Office use only:**

**Please Suspend patient from Patient Portal Registration. Our preference is: GP2GP/ EDI: waikatou**

|  |  |  |
| --- | --- | --- |
| **GP:** | **NZMC:** | **To:** |
| **Student Health Service**  | **12345** |  |
|  |  |  |
|  |  |  |

**Student Health Service**

*Hauora Ākonga*

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