

Office use only Signed & Dated <input type="checkbox"/> Faxed <input type="checkbox"/> Visa & Passport <input type="checkbox"/> Scanned <input type="checkbox"/> NHI <input type="checkbox"/> Text C <input type="checkbox"/> Request Notes <input type="checkbox"/> Portal C <input type="checkbox"/> Enrolled <input type="checkbox"/> Entered <input type="text"/>	AUCKLAND FAMILY MEDICAL CENTRE PATIENT ENROLMENT FORM 	Dr Sheelagh James - #16157 <input type="checkbox"/> Dr John McCartie - #13621 <input type="checkbox"/> Dr Phillipa Murray - #18233 <input type="checkbox"/> Dr Rebecca Little - #69391 <input type="checkbox"/> Dr Mei Ling Lee - #20770 <input type="checkbox"/> Dr Wei Long - #51193 <input type="checkbox"/>
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auckfamc	94 Remuera Road, Remuera 1050	524 6249	524 5230	
EDI Number	Address	Phone Number	Fax Number	NHI (Office use only)

Legal Name				
	(Title)	Given Name	Other Given Name(s)	Family Name
Other Name(s) (e.g. maiden name) Please tick the name you prefer				
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 Do you wish to receive text messages yes no	Home Phone	Email Address
Emergency Contact	Name	Relationship	Mobile (or other) Phone

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

Are you a smoker? **Yes** **No** **Never** **If yes would you like help to quit.**

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

Ethnicity Details	<input type="radio"/> New Zealand European <input type="radio"/> Tongan <input type="radio"/> Maori <input type="radio"/> Niuean <input type="radio"/> Samoan <input type="radio"/> Chinese <input type="radio"/> Cook Island Maori <input type="radio"/> Indian <input type="radio"/> Other (such as Dutch, Japanese)	
Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>		

My declaration of entitlement and eligibility

a	I am a New Zealand citizen <i>(If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below)</i>	<input type="checkbox"/>
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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:

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	<input type="checkbox"/>	Evidence sighted <i>(Office use only)</i>
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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.

Patient Survey

From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.

Patient Survey Contact Details: As provided above

I do not wish to participate in the Patient Survey

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"/>	<input type="checkbox"/>
			Self-Signing	Authority
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)			

Auckland Family Medical Centre New Patient Medical Questionnaire

Please complete one form for each member of your family 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 >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

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 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, how much/week _____*
and what type _____

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

9. Women: (those over 20 years & sexually active)

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, if so where? _____ No Don't know

IMMUNISATION RECORD: Please provide a copy of your immunisation record.

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.



Auckland Family Medical Centre
94 Remuera Road
Remuera
www.aucklandfamilymedical.co.nz

Auckland Family Medical Centre - Patient Portal Registration Form

Please complete this form and supply one form of photo ID to register for the Auckland Family Medical Centre patient portal.

Each person that uses the portal must have their own unique email address.

Full Name: _____

Date of Birth: _____

Email Address: _____

Cell Phone: _____

Signature: _____

Date: _____

Practice use only

Patient NHI: _____

Photo ID: _____

Staff Member: _____

Date: _____