Torbay Medical Centre	**ENROLMENT FORM** 1042 Beach Road, Torbay, Auckland, 0630 P: 09 477 9000 PO Box 89-146 F: 09 473 0557 Torbay EDI: torbay Auckland 0742

GP2GP: torbay	NHI *(Office use only)*
Dr Clare Dudding #29052 Dr David Thompson #12199 Dr Lynda Thwaites #21460 **Dr Jesse Joung #40828 Dr Rebecca Higgins #59377 Dr Sunee Kim #49723** **Dr Gareth Shalley #49968**	

Legal Name *	(Title)	Given Name	Middle Name(s)	Family Name
Other Name(s) (eg. maiden name /preferred name)		Preferred Name	Maiden Name	
Birth Details *		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender *		☐ Male ☐ Female	☐ Gender diverse (please state)	
Optional		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 /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

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, as I am only able to be enrolled at 1 practice at a time in NZ*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Address / Location	

Ethnicity Details** Which ethnic group(s) do you belong to? ***Tick the space or spaces which apply to you	○ New Zealand European ○ Maori ○ Samoan ○ Cook Island Maori ○ Tongan ○ Indian ○ Chinese ○ Other Asian (e.g: Korean) ○ Other (such as Dutch, Tokelauan). Please state	**Primary Language Spoken:** **IWI** * Smoking status (if over 15) Never smoked ☐ Ex-smoker ☐ Greater than 15months☐ less than 12 months ☐ Current smoker ☐ Would you like support to quit? Yes ☐ No ☐ ☐ I authorise Torbay Medical Centre to contact me via text message ☐ I authorise Torbay Medical Centre to contact me via email (non-secure)

* 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

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 Torbay Medical Centre I will be included in the enrolled population of Comprehensive Care 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 *(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)		

NAME: _____ D.O.B _____

Assess YOUR Risk Factors for Chronic Disease

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

Medical Problem	Self	Family
Diabetes (Type: 1 □ or 2 □ or Pre-diabetes □)	Yes □	Yes □
High blood pressure	Yes □	Yes □
Heart disease or problems	Yes □	Yes □
Heart attack (>60yrs□ or <60yrs□) or Angina□	Yes □	Yes □
Asthma	Yes □	Yes □
Other lung or respiratory disease/problem	Yes □	Yes □
Kidney disease or problem	Yes □	Yes □
Liver disease or problem	Yes □	Yes □
Bowel disease or problem	Yes □	Yes □
Joint disease or problem	Yes □	Yes □
Depression and/or anxiety	Yes □	Yes □
Other mental health illnesses	Yes □	Yes □

Medical Problem	Self	Family
Blood clot	Yes □	Yes □
Stroke □ or TIA □	Yes □	Yes □
High cholesterol	Yes □	Yes □
Migraine	Yes □	Yes □
Epilepsy	Yes □	Yes □
Breast Cancer	Yes □	Yes □
Other cancer	Yes □	Yes □
Glaucoma	Yes □	Yes □
Rheumatic Fever	Yes □	Yes □
Tuberculosis (TB)	Yes □	Yes □
Eczema	Yes □	Yes □
Hay fever	Yes □	Yes □

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

_____

_____

_____

3. Please list all **regular medications** that you take:

_____

_____

_____

4. Have you had any **operations** (including broken bones or hospital admissions)? - *please list and date*

_____

_____

_____

5. Are you allergic to any **medications**? - *please list*

_____

_____

_____

6. Do you **smoke**? No □ Yes □ – How many per day: _____ Would you like help quitting? No □ Yes □
Have you **ever** smoked? No □ Yes □
If yes – How many per day, how long for, and when did you quit _____

7. Do you drink **alcohol**? No □ Yes □ – How many per week: _____ Type:_____
(1 unit = 1 small glass wine, 300mL beer, 30ml (nip) spirit)

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

9. **Women** (those over 20yrs & sexually active):
When was your most recent cervical smear? _____
Have you ever had an abnormal smear? No □ Yes □ Don't know □
Have you had a mammogram (those over 40yrs)? No □ Yes □ Don't know □
Have you ever had diabetes during a pregnancy? No □ Yes □ Don't know □
Have you ever had a baby weighing more than 9lbs/4kgs? No □ Yes □ - _____kgs/lbs

10. When was your last **Tetanus** booster? _____

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

TorbayHealth

DEBT COLLECTION POLICY

The following is our debt collection policy:

"We pride ourselves on giving the best possible general medical care available, but in order to do that and keep our charges at a reasonable level, we would like you to be aware of our policy with regard to non-payment of your account. This is as follows:

- Payment of your consultation is expected on the day of consultation.
- When payment is not made immediately, accounts must be paid before the end of the calendar month. If payment is not made by that time, an administration fee of $5 will be added.
- Credit extending beyond one month must be arranged with the Practice Manager or the Doctor concerned, and alternative arrangements made for payment.
- All accounts extending past the 90 day due period will be referred to a debt collection agency (unless credit arrangements have been made) and the costs associated with this will be added to the patient's account for payment.
- Non attendance of confirmed appointments will incur a charge.
- Torbay Medical Centre reserves the right to vary this policy as it sees fit.

If you should have any queries regarding this policy, please do not hesitate to contact us.

We would appreciate your signature at the bottom of this form acknowledging that you have read this policy and understand the implications of non-payment.

I acknowledge that I have read the above policy and agree to abide by these terms of payment.

Name: _____ **Date:** _____

Signature: _____

TorbayHealth

PATIENT INFORMATION

환자분과 담당의와의 바람직한 관계 유지 및 개인정보유지를 위해, 본 병원의 방문자 사전 등록 절차와 뉴질랜드 의료규정에 대해 알려드리고자 합니다.

본 병원은 NZ Medical Council 의 방침 아래, 사전 예약 상담 시간 외에, 환자분이 개인적으로 담당의에게 연락 하는 것을 금하고 있습니다.

이는 병원의 상담시간 밖의 개인적인 전화, 문자 메세지, 카톡메세지, 페이스 북 메신저 등등, 상기 소셜미니어 상에서의 개인적인 연락과 병원 밖에서의 의료관련 상담을 포함합니다.

환자분의 건강 상의 이유로 예약 상담 시간외에 의료 문의 사항으로 도움이 필요하신 경우에는 본 병원 간호사에게 연락주시고, 진료시간 외 위급한 문제가 있으실 경우, 111 또는 아래 표기된 연락처로 문의 주시기 바랍니다.(list)

TMC would like to inform all our patients that communications of any medical concerns must be through booked appointments or via the nurses only.

We do not support contacting our doctors outside booked appointments via phone, text messaging and messengers of any kind, or in social settings. However, non-urgent messages via our 'Manage My Health' system is promoted.

It is vital for professionalism, sustainability of the patient-doctor relationship and our confidentiality policy that we keep these boundaries very clear.

I acknowledge and understand the above.

Signed:- _____

Dated:- _____