

Torbay Medical Centre	ENROLMENT FORM	
	1042 Beach Rd, Torbay, Auckland 0630	
	P: 09 477 9000	
	F: 09 473 0557	
	EDI: torbay	

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

Legal Name *	(Title)	Given Name	Middle Name(s)	Family Name
Other Name(s) (eg. maiden name /preferred 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)	
Optional	Marital status			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	<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

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, as I am only able to be enrolled at 1 practice at a time in NZ</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 Which ethnic group(s) do you belong to? Tick the space or spaces which apply to you	<input type="radio"/> New Zealand European	Primary Language Spoken:	
	<input type="radio"/> Maori		IWI
	<input type="radio"/> Samoan		* Smoking status (if over 15) Never smoked <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Greater than 15months <input type="checkbox"/> less than 12 months <input type="checkbox"/> Current smoker <input type="checkbox"/> Would you like support to quit? Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="radio"/> Cook Island Maori		<input type="checkbox"/> I authorise Torbay Medical Centre to contact me via text message <input type="checkbox"/> I authorise Torbay Medical Centre to contact me via email (non-secure)
<input type="radio"/> Tongan			
<input type="radio"/> Niuean			
<input type="radio"/> Chinese			
<input type="radio"/> Indian			
<input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state			
<input type="text"/>			

* My declaration of entitlement and eligibility *
--

I am entitled to enrol because I am residing permanently in New Zealand. <i>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>	<input type="checkbox"/>
---	--------------------------

I am eligible to enrol because:

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"/>
---	--	--------------------------

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>
--	--------------------------	---

<h2 style="margin: 0;">My agreement to the enrolment process</h2> <p style="margin: 0;">NB. Parent or Caregiver to sign if you are under 16 years</p>
--

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	<input type="checkbox"/> Self Signing	<input type="checkbox"/> 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 <i>(where signatory is not the enrolling person)</i>	Full Name	Relationship	Contact Phone
Authority Details	Basis of authority (e.g. parent of a child under 16 years of age)		

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

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 messages of any kind, or in social settings. However, non-urgent messages via "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.

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 소셜미디어 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)

I acknowledge and understand the above:

Signed:-

Dated:-

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	Medical Problem	Self	Family
Diabetes (Type: 1 <input type="checkbox"/> or 2 <input type="checkbox"/> or Pre-diabetes <input type="checkbox"/>)	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Blood clot	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
High blood pressure	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Stroke <input type="checkbox"/> or TIA <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Heart disease or problems	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	High cholesterol	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Heart attack (>60yrs <input type="checkbox"/> or <60yrs <input type="checkbox"/>) or Angina <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Migraine	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Epilepsy	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Other lung or respiratory disease/problem	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Breast Cancer	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Kidney disease or problem	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Other cancer	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Liver disease or problem	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Bowel disease or problem	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Joint disease or problem	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Tuberculosis (TB)	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Depression and/or anxiety	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Eczema	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Other mental health illnesses	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Hay fever	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

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
