HealthHubPROJECT
WELLNESS EDUCATION RESEARCH

Phone **06 358 7282**
www.hhpnz.nz

ENROLMENT FORM

NHI *(Office use only)*

Legal Name
Title | Given Name | Other Given Name(s) | Family Name

Other Name(s) (eg. maiden name)
Please tick the name you prefer to be known as

Occupation

Birth Details
Day / Month / Year of Birth | Place of Birth | Country of Birth

Gender
◯ Male ◯ Female ◯ Gender Diverse (please state)

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 Location | Town / City and Postcode

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

Contact Details
Mobile Phone | Home Phone | Email Address

Consent to use text messaging ◯ Yes ◯ No

I would like to receive electronic Patient Updates ◯ Yes ◯ No

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.

Previous Doctor and/or Practice Name | Address/Location

Acceptance of terms and conditions of credit:

- *All Accounts are Payable on the day that services are provided.*
- *I shall pay or reimburse you all costs and/or expenses incurred by you instructing a solicitor and/or debt collecting agency to recover any amount overdue for payment by me.*
- *An administration fee of $5.00 per overdue statement period may be added.*
- *I agree to be bound by the above terms and conditions in respect to this and all future transactions.*

I have a bad debt record or have had my account handed over to a debt collection agency

◯ Yes ◯ No

(A Yes or No answer will not affect your enrolment at Health Hub Project NZ)

Ethnicity Details

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

- ◯ New Zealand European (11)
- ◯ Maori (21)
- ◯ Samoan (31)
- ◯ Cook Island Maori (32)
- ◯ Tongan (33)
- ◯ Niuen (34)
- ◯ Chinese (42)
- ◯ Indian (43)
- ◯ Other (such as Dutch, Japanese, Tokelauan). Please state:

Patient Survey

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 do not wish to participate in the Patient Survey

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 entitlement criteria applies to you 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 B–J 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. *	☐ Yes
I understand that by enrolling with this practice I will be included in the enrolled population of the Primary Health Organisation (PHO) [Central PHO] this practice is contracted to, and my name address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers. *	☐ Yes
I understand that if I visit another health care provider where I am not enrolled I may be charged a higher fee. *	☐ Yes
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. *	☐ Yes
I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled. *	☐ Yes

Signatory Details

Signature _____

Date _____
Day / Month / Year

☐ Self-Signing ☐ Authority

Authority Details *(where signatory is not the enrolling person)*

An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Full Name _____

Relationship _____

Contact Phone _____

Basis of authority
(e.g. parent of a child under 16 years of age) _____

How did you hear about us ☐ Website ☐ Social media ☐ Word of Mouth ☐ Pharmacy ☐ TANCS | Other _____

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*If you require assistance to complete this form, please call our friendly team on **06 358 7282***

New Patient Health Questionnaire

Welcome to the Health Hub Project. This questionnaire is to help us to get to know your medical history. We recommend anybody over the age of 25, or who has a significant medical history to book an introductory New Patient Health check.

PERSONAL DETAILS

Full Name

Address

Phone number

Home phone | Mobile Phone | Work Phone

Date of Birth **Height** **Weight**

Your main or first language spoken/understood

MEDICAL HISTORY

		DATE OF LAST REVIEW	MEDICATION NAME
Respitory			
Asthma/COPD	◯ Yes ◯ No		
Breathing Difficulties	◯ Yes ◯ No		
Cardiac			
Heart Attack/Stroke	◯ Yes ◯ No		
Blood Pressure	◯ Yes ◯ No		
Irregular Heartbeat	◯ Yes ◯ No		
Other	◯ Yes ◯ No		
Diabetes	◯ Yes ◯ No		
Epilepsy	◯ Yes ◯ No		
Cancer	◯ Yes ◯ No		
Thyroid Disease	◯ Yes ◯ No		
Kidney Disease	◯ Yes ◯ No		
Mental Wellness	Discussions regarding the following can be had with your clinical team • Anxiety • Depression • Suicidal Thoughts		

Do you take any other medications not mentioned above?

FEMALE PATIENTS

Aged 20-70 yrs (date of last smear)

Aged 45-70 yrs (date of last mammogram)

OR please state if you DECLINE to have them

ALL PATIENTS

Have you had any serious illnesses or operations?
(Please state)

Please tell us if you have any known allergies
(i.e. penicillin, aspirin, plasters, nuts, bee stings etc.)

Do you have a carer? ◯ Yes ◯ No *If yes, who?*

Do you have Social Services help? ◯ Yes ◯ No

Are you registered either partially sighted or blind? ◯ Yes ◯ No *(please state)*

Are you registered with Work and Income? ◯ Yes ◯ No

Do you have any other disabilities? ◯ Yes ◯ No *(please state)*

Have you ever smoked? ◯ Yes ◯ No

Do you currently smoke? ◯ Yes ◯ No ◯ Prefer not to state

How many do you smoke per day?

Would you like help to quit? ◯ Yes ◯ No

Are you exposed to smoke at work? ◯ Yes ◯ No

Are you exposed to smoke at home? ◯ Yes ◯ No

How often do you drink alcohol?
◯ Prefer not to state ◯ Never ◯ Monthly or less
◯ 2 - 4 times per month ◯ 2 - 3 times per week ◯ 4+ times per week

How many glasses of alcohol do you drink on a typical day when you are drinking?
◯ Prefer not to state ◯ 1 - 2 ◯ 3 - 4
◯ 5 - 6 ◯ 7 - 9 ◯ 10+

Is there a history of any of the following in your family (father, mother, brother or sister) before age 65?

DISEASE		WHICH FAMILY MEMBER?
Heart Disease (heart attack, angina)	◯ Yes ◯ No	
Stroke	◯ Yes ◯ No	
Cancer	◯ Yes ◯ No	
Site of Cancer?		

Please list any other concerns that you may wish to discuss with your clinical team.

1.
2.
3.
4.
5.

www.hhpnz.nz

We are able to offer an online facility via ManageMyHealth to request repeat prescriptions and make general enquiries. To use this facility you will need to be issued with a unique login username and password, please ask our friendly Hosts for information.

Thank you for your time in completing this questionnaire.

Now that you are enrolled with the Health Hub Project NZ...

You can gain access to *Patient Portal*

We are able to offer an online facility to, request repeat prescriptions and make general enquiries. Simply fill out the consent form on the reverse of this page, and give it to one of our friendly staff.

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LOCATED IN PALMERSTON NORTH

Downtown Mall, Shop 25
491 Main Street
Palmerston North 4410
New Zealand

Ph. 06 358 7282 | **www.hhpnz.nz**

Patient Portal Consent Form

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MEMBER DETAILS:

Full Name:

Date of birth:

Day / Month / Year of Birth

Email:

Email login for *Patient Portal*

CHECKLIST:

- ◯ I am 18 years or older
- ◯ I am the only person who uses this email address
- ◯ I have read and understand the information regarding *Patient Portal* on this form.
- ◯ I have read and accept the terms and conditions of use, in the booklet provided.
- ◯ I am aware that this is a non-urgent service and for acute serious problems I will call the medical centre on 06 358 7282 or phone 111 in an emergency.
- ◯ I am aware that misuse of this service will result in suspension of my *Patient Portal* account

SIGNED: _____