TE AWAKAIRANGI PHO

UPPER HUTT HEALTH CENTRE ENROLMENT FORM

Queen Street Car Park PO Box 40-044 Upper Hutt Phone: 04 9201 800 Fax: 04 9201 808 EDI: familyuh

Title:	Surname: Preferred name: (if different from above):	First Name(s):
Date of Birth:		**Gender:** ☐Male ☐Female ☐ Diverse gender (Please specify)
Place/Country of birth:		Southern Cross or NIB Member No:
Address: Street number & name:		Suburb & City:
National Health Index (NHI) No:		Do you want to receive TXT reminders? ☐Yes ☐No
Phone:	Mobile:	**Register for Manage-My-Health?** ☐Yes ☐No
Email:		(Sign up for the MMH online portal to make appointments, see test results, request repeat prescriptions, email a nurse/ GP)

Ethnicity: (Tick the space(s) which apply to you)

☐ NZ European ☐ Maori ☐ Niuean ☐ Indian ☐ Chinese ☐ Cook Is Maori ☐ Samoan

☐ Fijian ☐ Tongan ☐ Other (please state) ……

Residency Status:	☐ Student Permit	Community Services Card Number: …… Expiry date:
☐ NZ Citizen	☐ Refugee	
☐ Permanent Resident	☐ Other	High Health User Card Number: …… Expiry date:
☐ Work Permit	☐ Passport/ID sighted	

Name of next of kin:	Next of kin's relationship to patient:
Next of kin's Address:	Next of kin's phone no:

**Only patients newly enrolling are to complete this section*

*Name of your previous GP and Medical centre:

Address of your previous GP/medical centre:

In order to receive the best care possible:

- I authorise Upper Hutt Health Centre to obtain my medical records from my current medical practice and I acknowledge that I will be removed from that practice's patient register.
- I understand that relevant health information may be shared with other health professionals directly involved in my care.
- I understand that my account/debt information may be shared with another health care provider and that any debt incurred will be forwarded to a debt collection agency for collection, which will impact on my future credit rating and incur associated costs.

I have read, and I agree to the **Primary Healthcare enrolment process** (please see over before signing)

Signature: _____ **Date:** _____

**If the patient is under 16 years, or there is a POA, please complete the following as the signing authority:*

Name:

Relationship: Signature: Date:

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Declaration of Entitlement, Eligibility and Agreement to the enrolment process

- **I intend to use Upper Hutt Health Centre** as my regular and ongoing provider of general practice / GP/ primary health care services
- **I am eligible to enrol** because **I live in New Zealand** and meet one of the following criteria:
    a) I am a New Zealand citizen **OR**
    b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) **OR**
    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 **OR**
    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 **OR**
    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 **OR**
    g) I am under 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder **OR**
    h) 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**
    i) 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 **OR**
    j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme **OR**
    k) 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
- I choose to enrol with Upper Hutt Health Centre as my regular and ongoing provider of general practice/GP/First Level primary health care services.
- I understand that by enrolling with Upper Hutt Health Centre I will be enrolled with Te Awakairangi Health (PHO) and my name and address and other identification details will be included on both the Upper Hutt Health Centre and the Te Awakairangi Health PHO Enrolment Register.
- I understand that if I visit another provider where I am not enrolled I may be charged a higher fee.
- I have been given the information about the benefits and implications of enrolment with the PHO, and their contact details.
- I have read and I agree with the Health Information Privacy Statement.
- I agree to inform the practice of any changes in my eligibility.
- I agree to pay for my consultation on the day at the time of my visit.
- I understand I will be charged if I do not attend a consultation that has been pre-booked.

To complete the enrolment process:

- ☐ Please make sure you have signed the enrolment form on the other side of this page.
- ☐ Provide 2 forms of ID
- ☐ Sign the UHHC Payment Policy

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Upper Hutt Health Centre Payment Policy

Paying fees

Payment in full is required at the time of your appointment. You can pay by cash, EFTPOS, cheque, MasterCard or VISA.

If you are unable to attend your consultation at least 2 hours' notice must be given. Failure to do this will incur a penalty charge.

If you're unable to pay your account on the day of your appointment, please talk to a member of our finance team about alternative payment arrangements.

If your account is unpaid at the end of the month and you haven't made any payment arrangements with us, we will:

- ask you to pay before you see a doctor or nurse for all appointments.
- reserve the right to review your enrolment with Upper Hutt Health Centre.

This policy forms part of the of the Upper Hutt health Centre enrolment process, compliance with this policy is mandatory.

Full name: ……..…….

Signature: ……..……

Date:……..…….

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LAST NAME:	FIRST NAME:	WEIGHT:…….. HEIGHT: ……..
DOB:	GENDER **(circle):** Female / Male / Diverse gender	OCCUPATION:
HOME PHONE:	WORK PHONE:	CELL PHONE:

Smoking Status: (please Tick which applies to you)

CURRENT SMOKER ☐
PAST SMOKER ☐
RECENTLY QUIT ☐
NON SMOKER ☐

Alcohol Status: (please circle which applies)

NON-DRINKER ☐
WITHIN SENSIBLE LIMITS ☐
ABOVE SENSIBLE LIMIT ☐

If you are a current smoker, would you like to quit smoking (please circle): **Yes / No**

HEALTH CONDITION: Do your Suffer from any of the following? (Please tick one or more that applies you).

	YES	NO
HEART ISSUES		
DIABETES (Type 1)		
DIABETES (Type 2)		
ASTHMA		
CHRONIC LUNG DISEASE (COPD)		

ALLERGIES Please specify……

ANY OTHER RELEVANT MEDICAL HISTORY NOT MENTIONED IN THIS FORM **e.g. Any Surgeries, Cancer or Dementia etc…**

……

Are you on three or more regular medications (please Circle) **YES / NO**

If **YES**, next script due? ..……

SCREENING HISTORY (Female only)

dd/mm/yyyy of last **MAMMOGRAM:** ____ / ____ / _____

dd/mm/yyyy of last **CERVICAL SMEAR**: ____ / ____ / _____

FAMILY HISTORY (excluding yourself)

HEART PROBLEMS **YES / NO** If Yes, Please give details + Family member Age: _____

……

STROKE **YES / NO** If Yes, Please give details + Family member: Age: _____

……

CANCER **YES / NO** If Yes, Please give details + Family member

……

DIABETES (Type 1 or 2) **YES / NO** If Yes, Please give details + Family member

……