FOR OFFICE USE ONLY **NHI:** **ENTERED/COMPLETED BY:** (staff initials)

☐ *Photo ID and Address sighted* ☐ *NES Enrolment* ☐ *Smoking status entered*

☐ *Notes transfer requested* ☐ *Tx Screening* ☐ *Scanned*

ENROLMENT FORM

WaihiFamilyDoctors

National Hauora Coalition

Physical Address: 43 Kenny Street, Waihi 3610
Postal Address: PO Box 262, Waihi 3641
Phone: (07) 863 2112
Email: reception@waihifamilydoctors.co.nz
EDI: waihidoc (Dr Tineke Iversen 28635)

*** Indicates fields that are COMPULSORY**

Name	Title / First Name*		Surname/Family Name*	
	Middle Name		Preferred Name	Maiden Name
Birth Details	Day/Month/Year*		Place of Birth*	Country of Birth*
Gender	☐ Male ☐ Female ☐ Gender Diverse (please specify)*			
Usual Residential Address	House Number and Street Name*		Suburb/Rural Delivery*	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*	Home Phone		Mobile Phone	
	I consent to receiving text messages ☐ Yes ☐ No			
Email Address				
Next of Kin / Emergency	Name*		Relationship*	Mobile (or other) Phone*

Ethnicity Details*

Which ethnic group(s) do you belong to?

Tick the space(s) which apply to you

☐	New Zealand European
☐	Maori
☐	Samoan
☐	Cook Island Maori
☐	Tongan
☐	Indian
☐	Other (please state)

Occupation

Employer

Employer Address

Smoking Status* (applies to 15 years of age and over)

☐ Never smoked ☐ Ex-Smoker ☐ Current Smoker ☐ Vaping

If you are a current smoker and/or vaper, would you like support to quit?

☐ Yes ☐ No

Preferred Pharmacy

☐Clarks ☐Barrons ☐Waihi Beach Chemist ☐Katikati Unichem

☐Other (please state) _____

Transfer of Records

In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor.
I understand that I will be removed from their practice register, as I am only able to be enrolled at one practice at a time in New Zealand.

☐ **Yes**, please request my transfer of records ☐ **No** ☐ Not Applicable (e.g. new born baby)

Previous Doctor and/or Practice Name

Practice Address / Location

Patient Portal – Manage My Health

I would like to sign up to Manage My Health and access my records online ☐ Yes ☐ No

Please note: you will need your own individual email address to access this service

I intend to use **Waihi Family Doctors** as my regular and ongoing provider of general practice / GP / First Level primary health care services. I am eligible to enrol because I live in New Zealand and meet one of the following criteria:

Please tick the option that applies ☑

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)
OR

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 years and in the care and control of a parent/legal guardian/adopting parent who meets one criterion in clauses a–f above
OR

h) ☐ I am 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

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 I have provided proof of my eligibility**

My agreement to the enrolment process

NB. Parent or Caregiver to sign if you are under 16 years

I choose to enrol with this practice as my regular and on-going provider of general practice / GP / First Level primary health care services.

- I understand that by enrolling with this practice I will be enrolled with the National Hauora Coalition, and my name address and other identification details will be included on both the Practice and the 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 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.

	/ /
SIGNATURE	**DATE**

If signed by AUTHORITY (under 16 years) -

Full Name of Authority	Contact Phone Number	Relationship
Detail the basis of authority (e.g. parent of a child under 16):		

WaihiFamilyDoctors

NEW PATIENT MEDICAL QUESTIONNAIRE For Adults 16 Years and Over

Please complete and submit one form for each adult member of your family. If you are unsure how to answer a sedction or need assistance with completing the form please talk with reception.

* Answers are required for all questions marked with an Asterix

Personal Information

Patients full name:					
DOB:	/ /				
Email:					
Guardian/caregiver - are you Completing on behalf of patient?	○ YES	Your full name			
	Relationship with patient			Phone:	

Community services card*	○ No	○ Yes
High user Health card	○ No	○ Yes

Employment Status* Tick which one applies, if employed:	○ Employed	○ Unemployed	○ Student	○ Not applicable
	Occupation			
	Employer name			
	Employer Address			

Accessibility and Support

Do you need help with mobility/hearing/vision/speaking	○ No	○ Yes - see below	
Please tick all that apply:			
O Wheelchair	○ Walking aid	○ Hearing Aid	○ Glasses/contacts
O Sign language	○ Lip reading	○ Braille	○ Other:

Do you require an interpreter*	○ No	○ Yes
Which language?		

Medication

List any **regular medications or tablets (***inc herbal***)** that you take:	

Are you allergic to anything (ie medications)	O No	O Yes	(If yes please list)

Medical History

Do you or anyone in your immediate family (parent, sibling, child) currently have or previously had any of the following:

Please Tick all that apply	You	Family		You	Family
Diabetes O Type 1 O Type 2	O	O	Heart attack or stroke O <age 50 O >age 50	O	O
High blood pressure	O	O	Bowel problems or disease	O	O
High cholesterol	O	O	Bowel cancer O <age 55 O >age 55	O	O
Heart disease	O	O	Other cancer	O	O
Angina	O	O	Skin cancer	O	O
Circulation issues	O	O	Blood clots or bleeding disorders	O	O
Mental health illnesses (depression/anxiety etc)	O	O	Liver problems or disease	O	O
Gout	O	O	Asthma	O	O
Reflux /GORD	O	O	COPD	O	O
Stomach ulcers	O	O	Hayfever	O	O
Osteoporosis	O	O	Eczema	O	O
Arthritis	O	O	Ear or eye problems	O	O
Seizure disorders/epilepsy	O	O	Tuberculosis (TB)	O	O
Kidney problems or disease	O	O	Thryoid disease	O	O
Breast cancer	O	O	Migraine headaches	O	O
Prostate cancer	O	O	Multiple sclerosis	O	O
Surgeries or operations?					
Other conditions/Comments:					

Screening – Women

If 25 year or older, have you had a **Cervical Smear?**	O No	O Yes	O Don't know
Have you ever had an **abnormal smear**?	O No	O Yes	O Don't know
Have you had a hysterectomy and been told no more smears?	O No	O Yes	O Don't know
If >45 years, have you had a **Mammogram?**	O No	O Yes	O Don't know
If >45 and <69, are you enrolled in *Breastscreen Aoteoroa*?	O No	O Yes	O Don't know

If not enrolled in *Breastscreen Aoteoroa*, and are eligible, do we have your consent to enrol you on this programme?	○ Yes	○ No, I decline to enrol

Screening – Men

Do you know when your last **men's health** check up was?	○ Yes (date/year)	○ No

Immunisations

When was your last **Tetanus** booster?	Don't know	(Date/year)	
Are your childhood immunisations up to date?	○ No	○ Yes	○ Don't know
Have you received the **human papilloma virus (HPV**) vaccine	○ No	○ Yes	○ Don't know
Have you received the **MMR** vaccine?	○ No	○ Yes	○ Don't know
Have you received the most recent **flu** vaccine?	○ No	○ Yes	○ Don't know
Have you received a **covid-19** vaccine?	○ No	○ Yes	○ Don't know

Lifestyle

Physical activity	How often do you exercise?	○ Daily	○ Once weekly	
		○ 2-3 x week	○ Less than once weekly	
	Do you think your exercise is?	○ Light	○ Moderate	○ Strenuous
Smoking/vaping	○ **Never smoked /NA**			
	○ **Ex smoker**	What age did you **start** smoking?		
		What age did you **stop** smoking?		
		Average number of cigarettes/day smoked?		
	○ **Current smoker**	What Year did you started smoking?		
		Average number cigarettes/day smoked		
		Do you consent to referral to smoking cessation	○ Yes	○ No
	○ **Current vaper**			

Alcohol intake	How often do you have a drink containing alcohol	○ Never	○ 2-3 x week	
		○ Monthly or less	○ 4-5 x week	
		○ 2-3 x month	○ 6-7 x week	
	How many drinks containing alcohol do you have on a 'typical day' when drinking	○ 1-2 drinks	○ 7-8 drinks	
		○ 3-4 drinks	○ 10 or more drinks	
		○ 5-6 drinks		
	How often do you have 6 or more drinks on one occasion	○ Never	○ Weekly	
		○ less than monthly	○ Daily or almost daily	
		○ Monthly		
Other substance use	Do you use any of the following substances?	○ Cannabis	○ Methamphetamine	
		○ Other?		
	Do you have any concerns about your substance use?		○ Yes	○ No

Social Situation

Living Situation	What is your living situation today	○ I have a steady place to live	
		○ I have a place to live today , but I am worried about losing it in the future	
		○ I do not have a steady place to live (temporary accommodation with others/motel/hotel/car/street)	
	Do you have concerns about the following problems in your current living situation? (**select all that apply)**	○ Pests	○ Water leaks
		○ Mould	○ none of the above
		○ Lack of heat	○ Other
		If Other, please state:	
Food Availability	In the past 12 months have you worried that your food might run out before you had money to buy more?		○ Never
			○ Sometimes
			○ Often
Transportation	Do you have a current Drivers licence?		○ Yes ○ No
	In the past 12 months has lack of reliable transportation kept you from medical appointments, meetings, work or getting things needed for daily living?		○ Yes ○ No

Signed	
Date	