200 Mangorei Road Merrilands
 New Plymouth 4312
**Ph:** 06 758 8773   **Fax:** 06 757 8053
**Email:**email@merrilandsmedical.co.nz

Patient Registration Request
Thank you for your interest in registering at Merrilands Medical Centre. We aim to provide the highest quality of comprehensive medical care from our dedicated team.

As part of our comprehensive approach to health care, the first full consultation with new patients needs to be longer than a usual consultation to allow for accurately checking and documenting past medical history along with any current problems. There is significant data to be established within our computerised patient notes to ensure important medical considerations are not overlooked during the transition from one practice to another. **To allow this process we book a double appointment for all adult new patients, aged 35 yrs and over, on their first consultation. This does attract an additional fee for this first consultation of $30 above the usual fee, however it provides a safe and thorough starting point for your medical care with Merrilands Medical Centre**. If the physical past medical records are not yet available from your previous Doctor we will go through them once they arrive.

Please read through the following Terms of Trade and when you wish to proceed with registering at Merrilands Medical Centre, complete this form, the accompanying Primary Health Organisation (PHO) Enrolment forms and send or give to reception at Merrilands Medical Centre. Each adult, aged over 16yrs, must complete this form separately.

I, ……………………………………………………………            DOB            /         /

**Hereby request to become a registered patient at Merrilands Medical Centre**

I acknowledge and understand that by making this request I agree to enrol with the associated Primary Health Organisation (PHO), namely Midlands Health Network, which will require a separate enrolment form to be completed. By doing this I will be eligible for the Government subsidies for health care.
I have attached **Proof of Identity and Eligibility:**

**For NZ Citizens:**

* A New Zealand passport **OR**
* A New Zealand Birth Certificate (or Cook Island, Niue or Tokelau birth certificate) **AND** one form of photo ID
* A New Zealand Certificate of Citizenship **AND** one form of photo ID
* A Descent Registration Certificate one form of photo ID one form of photo ID
* Evidence the person is currently getting a social security benefit (except emergency benefit) **AND** one form of photo ID

**For Foreign Nationals:**

* Must show a passport with relevant Visa/Permit
* Australian citizens must provide proof that they intend to stay in New Zealand for at least 2 consecutive years

I agree to comply with the Terms of Trade of Merrilands Medical Centre which include:

* The **first consultation** for adult patients attracts a $30 additional fee to allow for a **double** consultation to conduct a comprehensive medical history review, update of electronic records, medications, allergies etc to ensure Merrilands Medical Centre has all necessary information to ensure the best patient care. I understand that this first consultation must be paid in its entirety at the time of the consultation.

* I agree to advise of any **change of address or contact details** and that failing to do so may result in my enrolment status with the PHO being changed by the Ministry of Health. Government subsidies are then  withdrawn by the Ministry of Health which will result in higher consultation charges until such time as that status can be updated, typically 3 months.

* I understand that I have a responsibility to attend for consultations, if requested, before the prescribing of repeat routine medications.

* I understand that I will be charged a cancellation fee if I do not attend an appointment or cancel within 24 hours of the appointment time.

* I agree to comply with the financial requirements that would usually include payment on the day of consultation unless prior arrangement is made.

* I agree to be financially responsible for any collection costs that may be incurred through late payment of accounts.

* I agree to treat the Medical, Nursing and Administrative staff with respect and in a polite manner at all times.

I understand that breach of the above Terms of Trade may result in a written request for me to transfer my care to another medical centre. I agree to do this within three weeks. I also agree that I will be de-registered at Merrilands Medical Centre in this circumstance.

Signed ........................................................................

Date ...................................

200 Mangorei Road Merrilands
 New Plymouth 4312
**Ph:** 06 758 8773   **Fax:** 06 757 8053
**Email:**email@merrilandsmedical.co.nz
**GP2GP details = Doctors name: Merrilands  NZMC: 49168  Healthlink: merrilan**

**PATIENT ENROLMENT FORM**

Each person 16 years or over to complete and sign own form    \****must*** *be completed*

|  |  |
| --- | --- |
| Personal Details: | NHI: (office Use only)\* |
| Family Name:\* | First Name/s:\* | Title: |
| Preferred Name: | Date of Birth:\*                                          /            / | Gender:\*    (please circle)Male / Female or Gender Diverse  |
| *Physical Address:\**  | Unit/ house no: | Street: | Suburb: |
| Postcode: |  | City: |
| Work Phone: | Home Phone: | Mobile Phone: |
| Postal address: *(Complete if different from above)* |
| *Postal Address:*  | PO Box /Unit/ house/ no: | Street:and city | Suburb/Rural Delivery/Postcode: |
| Email address: |
| Preferred method of contact: (Circle all that apply)                        Email:                             Text:                        Landline:                       Cellphone:                         Post:               |
| Medical Insurance:      No     Yes          Company name:If you are a Southern Cross Member, Policy number: |
| Employers details:                                                                                                 Occupation: |
| WINZ number |  | High User Health Card  |  | Expiry Date: |

Which ethnic group do you belong to? (You may select up to three ethnicities):\* - **Please circle**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |
| 1-21*NZ Māori* |  | 6-32*Cook Island Māori* |  | 12-42*Chinese* |  | 18-61*Other (please state):* |  |
| IWI:                     | 7-31*Samoan* |  | 13-44*Other Asian* |  | 19-12*Other European(please state below)* |  |
| 2-35*Tokelauan* |  | 8-37*Other Pacific* |  | 14-40*Asian not further defined* |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 3-36*Fijian* |  | 9-30*Other (Pacific Island not further defined)* |  | 15-52 *Latin American/Hispanic* |  | 20-10*Other European not further defined* |  |
| 4-34  *Niuean* |  | 10-41 *South East Asian* |  | 16-53 *African* |  | 21-11 *NZ European/Pākehā* |  |
| 5-33 *Tongan* |  | 11-43 *Indian* |  | 17-51 *Middle Eastern* |  | 95 *Declined* |

Residential Status

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Town/Country of Birth:\* | If not born in NZ are you a NZ resident?     Yes              No | Are you on a working visa?  Yes               No | Expiry Date:         /      / | Are you a Refugee:  Yes         No |

Next of Kin/Emergency Contact Details:

|  |  |  |  |
| --- | --- | --- | --- |
| Title: | Family Name: | First Name/s: | Relationship: |
| *Address:*  | Unit/ house no: | Street: | City: |
| Suburb: |
| Day Phone: | A/H Phone: | Mobile Phone: |

Smoking status *is an important factor influencing health please tick the space that applies to those aged 15 and over*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name |   |  |  |  |  |  |
|  | never smoked |  |  I have smoked daily for more than a year but no longer smoke |  | I am a smoker |  |

*Please complete a new form for any dependent children that you wish to enrol in this practice and you are legally entitled to sign on their behalf.****PLEASE NOTE:***Any one over the age of 16 must sign their own form

**Enrolment in the Practice / Primary Health Organisation (PHO)**

**I intend to use Merrilands Medical Centre** as my regular and ongoing provider of general practice / GP / First

Level primary health care services. **I am entitled to enrol** because I am residing permanently in New Zealand and

intend to remain here for at least 183 days in the next 12 months:             **Yes   /   No**

I meet one of the following eligibility criteria:

|  |  |
| --- | --- |
| a) I am a New Zealand citizen     **OR**  | Yes / No |
| b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) | Yes / No |
| 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 | Yes / No |
| 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) | Yes / No |
| e) I am an interim visa holder who was eligible immediately before my interim visa started | Yes / No |
| 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 | Yes / No |
| 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 | Yes / No |
| 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 | Yes / No |
| 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) | Yes / No |
| j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme | Yes / No |
| 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. | Yes / No |

**I confirm that, if requested, I can provide  proof of eligibility.  YES / NO                       Evidence sighted

My agreement to the enrolment process:**

* **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 Midlands Regional Health Network Charitable Trust , 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 Midlands Regional Health Network Charitable Trust , 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 all consultations at the time of my appointment and any costs incurred in collection after 30 days will be my responsibility.***
* I authorise this practice to obtain copies of any health information about me from the practice I previously attended (where this is my first enrolment with this practice), for the purposes of recording my health status and to assist in my further care and treatment.
* I authorise my previous practice to disclose this health information to this practice via GP2GP (details on page 1)
**Previous doctors details:
………………………………………………………………………..............................................................................**
* I consent to Merrilands Medical Centre storing and using my mobile telephone number for communication via text messaging, for appointment and review reminders

|  |  |
| --- | --- |
| **FULL NAME\*** |                                                                                          /                /Day        Month       Year |
| **SIGNATURE\*** | **DATE\*** |

**OR Signed by AUTHORITY ⁵ (must have the legal right to sign on behalf)**

|  |  |  |
| --- | --- | --- |
| Full Name of Authority | Contact Phone Number | Relationship |
| Address | Signature of Authority |                       /                 /          Day        Month       Year |
| Name & Detail the basis of authority (e.g. parent of a child under 16): |

⁵An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

**NOTE:**  **For Children** - **Please provide a copy of their Plunket book Immunisation record (if able)

1.  Family History:**

Do any members of your close family suffer from the following: (state what relationship they are to you)

Heart Disease .......................................................                            Hay Fever .........................................................

Diabetes ................................................................                            Eczema .............................................................

Asthma ..................................................................

Cancer (if yes what type) .........................................................................................................................................

Other  .......................................................................................................................................................................

**2.  Female patients:**

When did you last have the following?

Cervical Smear: ....................................    Mammogram:  ....................................

IUCD inserted: ....................................

**3.  Screening:** (eg Cholesterol, PSA, Depression etc)

Are you aware of any other screening you may have had with your previous doctor:

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**4.  Social History:**

How much alcohol would you consume in an average week?  .........................................................................................

**5.  Allergies:**

Please list anything you are allergic to (including foods, drinks, medicines) ***and your reaction to them:***

 (if unknown please state unknown)

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**6.  Medications:**

Please list any medicines that you are currently taking.  We would also like to know if you are taking any other medicines that you may have purchased over the chemist counter or at the health shop.

***Medications purchased at Chemist or Health shop***

**Patients Name:                                      Dose:                                       How often taken: (eg daily, twice daily etc)**

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