NGONGOTAHA
HEALTH CENTRE

Ngongotaha Medical Centre
17 Taui Street
Ngongotaha

Ph 07 357 1030
Email reception@nmc.org.nz

INSTRUCTIONS FOR ENROLMENT REQUEST

Please write with Black Pen only

Note: Patients enrolled with another Rotorua Medical Practice are not currently *eligible*
Note: Patients need to live in the Ngongotaha/Mamaku/Hamurana area

Before your Enrolment Application can be considered we require the following:

1 Completed & signed Enrolment Form

2 Completed Medical History Form

3 Proof of Address
(examples: Utility Bill, Rates notice, Bank Statement or other official letter showing address)

4 **ID if born in New Zealand - one of the following**

New Zealand Passport; or

children under 18 yrs Birth Certificate

adults Birth Certificate / Photo ID (drivers license, R18 card, etc)

4a **ID if born anywhere other than New Zealand – one of the following:**
Australian Passport
Passport with current relevant Visa (for a minimum of 2 years)
Permanent Resident Visa
NZ Citizenship Certificate or NZ Passport

5 Proof of City and Country of Birth (*examples passport, birth certificate)*

Signing Authority for another Person:

Parents have authority to sign for a child under the age of 16 years.

If not a parent of child under 16 years of age then Court appointed guardianship papers are required

Please allow 14 working days for enrolments to process, and medical records transferred

NGONGOTAHA MEDICAL CENTRE

ENROLMENT FORM

Ngongotaha Medical Centre Ltd
17 Taui Street
Ngongotaha, ROTORUA
Telephone: 07–3571030 – Fax 3574197
EDI: ngongomc

DR Jane CARMAN, M.C.N.Z 22630
DR Simon J FIRTH, M.C.N.Z 16819
DR Jorgelina FERREIRA, M.C.N.Z 44108

DR Kingsley ANEKE, M.C.N.Z 43911
DR Genevieve MATTHEWS, M.C.N.Z 38431
DR Louisa BARTER, M.C.N.Z 46507

NHI ***(Office use only)***

Name (Title)	**Given Name**	**Other Given Name(s)**	**Family Name**
Other Name	Other Name	Other Given Name(s)	Other Family Name (eg. maiden name)
Preferred Name	Preferred Name	Preferred Other Given Name(s)	Preferred Other Family Name
Birth Details	**Day / Month / Year of Birth**	**Town/City of Birth**	**Country of birth**
Gender	☐ **Male** ☐ **Female** ☐ **Gender diverse (please state)**		Occupation

Usual Residential Address	**House (or RAPID) Number and Street Name**	**Suburb**	**Town / City and Postcode**
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb	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	
Emergency Contact	Name		Relationship	Mobile (or other) Phone

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

New Zealand European	
Maori *Iwi/Hapu:*	
Samoan	
Cook Island Maori	
Tongan	
Niuen	
Chinese	
Indian	
Other (such as Dutch, Japanese, Tokelauan). Please state:	

Smoking Status: *Tick as applicable:*

Non Smoker	
Ex Smoker	
Current Smoker	
How Many per Day?	
Would you like help Quitting? (Circle if applicable)	Y N

Photo ID. Presented: Y/N *Tick as applicable:*
YES: ☐ **NO:** ☐

Employment Details: *For ACC purposes*

Name of Employer:	
Address of Employer:	
Contact Details:	

Transfer of Records: **We Prefer GP2GP** Please untick NOK before sending	*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.*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Address / Location	

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 *(One of the boxes below (a-j) must be ticked if you are eligible for funded visits)*:

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 (b–j) 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 a–f above and 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	☐

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. This includes enrolment in MyIndici, the Patient Portal application operated by the Practice.

I understand that by enrolling with this practice I will be included in the enrolled population of the Primary Health Organisation (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.

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	☐ Self Signing	☐ 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 *(where signatory is not the enrolling person)*	Full Name	Relationship	Contact Phone
Authority Details	Basis of authority (e.g. parent of a child under 16 years of age)		

Personal and Family Medical History

NGONGOTAHA MEDICAL CENTRE

Please Complete in - BLACK PEN

Name:		**Date:**
Date of Birth:	**Gender** *(circle)* **Male / Female/ Other**	**Do you need an interpreter?** ☐ **Yes** ☐ **No**

We regularly contact our patients as part of their care. Please could you let us know if you agree to receive the following information using email or text by putting yes or no in the following

Email	Test results	Appointment reminders	Recalls for services such as cervical smear, immunisation, blood test
Text	Test results	Appointment reminders	Recalls for services such as cervical smear, immunisation, blood test

1. **Thank you for filling in this form before your appointment, as we can keep your information on file to help you provide the highest quality care. There are two pages to this questionnaire. The information will be kept with your confidential health records.**

Please bring your current medications, inhalers etc. with you to your appointment.

Do you have any allergies and reactions	☐ **Yes**	☐ **No**

– Please specify the name and type of reaction if you know it.

Other important alerts *- Please indicate other things that are important for your health record*

No Transfusions	Needle phobia	Organ donor
Power of Attorney	Resuscitation instructions	Other

Smoking history *(please circle)*		Never smoked	Past smoker	Current smoker
How many per day	Less than 10	10-19	20 or more	

Would you like to have support to stop smoking:	Yes	No

Alcohol Use

What type of alcohol do you usually drink:	**None**
How much/often:	

Domestic violence

Have you ever been exposed to domestic violence?	Yes	No

Personal and Family Medical History

NGONGOTAHA MEDICAL PRACTICE

Please Complete in - BLACK PEN

Personal History

☐ Asthma	☐ Emphysema	☐ Chronic lung disease
☐ Acid reflux	☐ Stomach Ulcer	☐ Other chronic infection
☐ Hepatitis B	☐ Hepatitis C	

☐ High Blood pressure	☐ No	☐ Heart attack	☐ No
☐ Heart Operation ..... ☐	☐ No	☐ Angina	☐ No
☐ Irregular heart beat eg Atrial Fibrillation	☐ No	☐ Stroke	☐ No
☐ Diabetes Type:	☐ No	☐ Cancer Type:	☐ No
☐ Depression or related illnesses	☐ No	Other medical or family conditions	
Other hospital admissions	☐ No	Other operations and injuries	☐ No
Anything else that needs to be discussed	☐ Yes	☐ No	

Family History

☐ High Blood pressure	☐ No	☐ Heart attack *Who and age*	☐ No
☐ Stroke *Who and age*	☐	☐ Cancer Who and age:	☐ No
☐ Angina *Who and age*	☐ No	Type:	
☐ Diabetes Who and age:	☐ No	Other medical or family conditions	