ENROLMENT FORM

PYES PA DOCTORS

Pyes Pa Doctors		Pyes Pa Shopping Centre, Unit 8, 83 Pyes Pa Road, & 1 Caslani Lane, The Lakes Shopping Village, Pyes Pa, Tauranga	
Providers: Drs Simon Roberts, Stephanie Kramer, Sue Genner, Ruth Cameron, Murray Hay	**NZMC #**	**EDI** (GP to GP Electronic File Transfer) tauranga	**NHI**

*** Indicates Fields that are COMPULSORY** **Fields above for Office Use ONLY**

Legal Name	Title	Surname/Family Name*	First/Given Name*	
	Middle Name(s)*	Preferred Name	Maiden Name	
Birth Details	Day / Month / Year of Birth*	Place of Birth*	Country of Birth*	
Gender	☐ Male ☐ Female ☐ Gender diverse (please state)*		Primary Language	

Usual 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 Delivery	Town / City and Postcode
Contact Details	Mobile Phone / Home Phone	Email Address	

Next of Kin / Emergency Contact	Name	Relationship	Mobile (or other) Phone
	Address		

Community Services Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number (if known)
High User Health Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number (if known)

Ethnicity Details

Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you

- ☐ New Zealand European
- ☐ Maori
- ☐ Samoan
- ☐ Cook Island Maori
- ☐ Tongan
- ☐ Niuean
- ☐ Chinese
- ☐ Indian
- ☐ Other (such as Dutch, Japanese, Tokelauan). Please state:

IWI	
Occupation	
Employer & Address	

Smoking Status (applies to 15 years & over ONLY)

Never smoked ☐ Current smoker ☐ Ex-smoker ☐

Approximate Quit Date_____

Smoking is bad for your health. Would you like support to quit? Yes ☐ No ☐

Consent to Receive Communications via *Email - Text - Patient Portal* *(if available)*

Please tick applicable boxes to give your consent:

☐ Text Message ☐ Patient Portal (secure)

☐ Email (non-secure)

Transfer of Records Authority

In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor.
I understand I will be removed from their practice register, as I am only able to be enrolled at 1 practice at a time in NZ.

☐ Yes - please request transfer of my records ☐ Not Applicable ☐ No	Previous Doctor and/or Practice Name
Signature Day / Month / Year	Practice Address / Location

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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 eligibility 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 **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 I have provided 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.

I understand that by enrolling with ***(insert practice name)*** I will be included in the enrolled population of **Western Bay of Plenty PHO** 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 or informed 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 shared 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.

I agree to the Terms and Conditions of Trade of (*insert practice name*) and undertake to pay any fees applicable for Practice Services & all costs incurred in collection of any debt for myself & my dependents.

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

PYES PA DOCTORS

ADULT QUESTIONAIRE FOR DATABASE PROFILE (15 Years & Over) **Date: ……../……../……**

Name: ……. **D.O.B. ……** **Age: ……**

The following information is requested for inclusion in your records to enable staff to better understand your medical background.

Previous Medical History: (*Please Tick)*

Condition	Yes	No	Condition	Yes	No
Asthma / Bronchitis / COPD			Heart Disease		
Arthritis / Joint problems			Hepatitis / Liver problems		
Diabetes			Headaches / Migraines		
Epilepsy / Blackouts			Kidney / Bladder / Prostate problems		
High Cholesterol			Skin problems		
High Blood Pressure			Vision / Hearing / Speech		
BP check in the past 12 months?					

List any other significant medical illnesses / injuries / operations / hospital admissions:

_____ Date: _____

_____ Date: _____

_____ Date: _____

What is your family history? *Tick those that apply*

Medical History	Father	Mother	Sister	Brother	Children
Diabetes					
Heart Disease					
Stroke					
High blood pressure					
Cancer (specify type)					
Other hereditary illness (specify)					

Current Medical History:

1. **ALLERGIES - Do you have any known allergies (eg- medications, egg)** *Specify type of allergy& describe reaction*

   _____

   _____

2. **ALCOHOL - What is your weekly alcohol intake?** _____

3. **SMOKING - Are you a smoker? Yes / No**
   If YES, *we strongly encourage you to stop smoking* for the benefit of your health.
   Would you like support to help you stop smoking? Yes / No

Office Use Only:	IMMS/FLU	CVRA	DAR	CX	MAM	Initials:

ACCOUNT PAYMENT POLICY of

TAURANGA HEALTHCARE LTD

(Trading as Pyes Pa Doctors)

We seek to provide the best possible general medical care. In order to do that, and to keep our charges at a reasonable level, we have the following payment policy:

- Same day payment is expected for all services.
- Payment via internet banking can be made into our bank account: **06-0541-0823026-25**. Please put your chart No. or full name as the reference.
- A DNA (Did Not Arrive) charge is placed on your account if you do not arrive for your appointment and do not ring us in advance. This includes a DNA charge for children under 14 years.
- Where a balance is owing at the end of the month, a Statement will be sent out which will include a $10 administration fee (non-refundable).
- Credit extending past 30 days must be arranged with the Practice Manager or the Receptionist, and alternative arrangements made for payment (including setting up Automatic Payments into our account).
- Accounts extending past 60 days may be sent to a debt collection agency, unless credit arrangements have been made. The costs associated with this will be added to the account for payment.
- Any patient sent to the debt collection agency will not be allowed further credit and will be asked to pay for further consultations prior to being seen.

If you have any queries regarding this policy, please contact the Practice Manager.
A copy of this form for your records is available from our receptionist, upon request.

I have read the above policy and agree to abide by these terms of payment.

(Print full name and sign – one per adult)

Name: _____ Signature: _____

Date: _____