Southside HEALTH

10F Newnham Street
Rangiora
Phone: 03 313 5252
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Email: admin@southsidehealth.co.nz

INFORMATION FOR PATIENTS ENROLLING AT SOUTHSIDE HEALTH

To access funding benefits provided by the Ministry of Health, patients must be registered with a single medical centre. Whilst our surgery can treat patients on a "Casual" basis, these appointments incur higher fees. Our doctors will also not have immediate access to your medical information. To enrol as a patient at Southside Health we would be grateful if you could take the time to complete the Request to Transfer Notes and Medical Information Forms and return these to our receptionist together with your Enrolment Form. The information collected from you on these forms includes:

YOUR PERSONAL DETAILS: Full name, date of birth and gender are required so that you can be identified from your records

NATIONAL HEALTH INDEX NUMBER (NHI): This is your own unique number used by health providers to identify you (if you do not know this number we can find this information for you).

ETHNICITY: The Ministry of Health requires this information for statistical purposes to assist them to meet their obligations under the Treaty of Waitangi. This information can also assist the practice to arrange services to meet your specific needs.

COMMUNITY SERVICES/HIGH USER HEALTH CARD: If you hold one of these cards it may entitle you to additional subsidies.

NEXT OF KIN: It is important for us to know who to contact in case of an emergency. Where possible, we require two emergency contacts for each patient.

RESIDENCY STATUS: Your entitlement to subsidised health care is dependent on your residency status. If you are not a NZ citizen or permanent resident we may ask you to provide some extra information.

IN ADDITION:

* All patients over the age of 16 years are required to sign their own enrolment form.
* The information provided on your enrolment form remains confidential. Contact details may be used in future to let you know of any appointments, test results etc so it is important to let staff know if you do not want confidential communication through these channels. It is also important to advise us of any changes in details while enrolled with us.
* All new patients are required to attend for:
  One 15 minute FREE appointment with the nurse prior to their first GP appt. This is to collect information to continue your medical care and streamline quality time with your doctor.
* Patients seeing a SSH GP for the first time must book a double appt which will also incur a double appt charge
  Please make sure that you advise the receptionist when booking that your appointment is a 'new patient consultation' with the nurse and GP.

TERMS OF TRADE:

The following Terms of Trade apply to services provided by Southside Health Trust to its patients. By signing an enrolment form, you agree to the Terms and Conditions of Trade as stated:

1. Prices include GST unless otherwise stated.
2. Prices quoted for services may be adjusted from time to time, and the patient agrees to pay the adjusted price. e.g. in instances where cost of goods increases, government surcharges increases, errors or omissions by Southside Health Trust or its representatives.
3. Unless otherwise agreed, all services shall be paid for on the date of service.
4. Payment shall be accepted in the form of cash, cheque, eftpos, credit card or direct credit.
5. Where it is agreed that payment need not be paid on the day of service, it shall be paid by the end of the month in which the consultation takes place. Accounts will incur a $10.00 administration fee per consultation.
6. Southside Health Trust reserves the right to withhold further provision of service where there is any outstanding amount due.
7. Where patients are in breach of agreed payment terms, debt collection and/or legal proceedings may follow. Costs incurred to recover outstanding monies will be charged to the patient.
8. Termination of the contract may apply where there is non-payment, without prejudice to any claims Southside Health Trust may possess.

PATIENT ENROLMENT FORM

Each person 16 years or over to complete and sign own form

Office Use Only					
Received		**Entered**		**Checked**	
Initial	Date	Initial	Date	Initial	Date

Doctor Name:	**NZMC No:**	**EDI: sthsideh**	**NHI:**
Bevan Rogers	**10208**		

1. Personal Details

Legal Name	**Title**	**Given Name**	**Other Given Name(s)**	**Family Name**

Other Name/s Known By	**Other Family Name (eg. Maiden name)**

Preferred Name	**Date of Birth**	**Place of Birth**	**Country of Birth**

Gender **Male** ☐ **Female** ☐ **Gender Diverse** (please state) ☐

2. Contact Details

Usual Residential Address

Unit/House No.	**Street**	**Suburb**

Town/City	**Postcode**

Postal Address

PO Box Unit/House No.	**Street**	**Suburb/Rural delivery**

Town/City	**Postcode**

Work Phone	**Home Phone**	**Mobile Phone**

Email Address

Consent to Use Text Messaging Yes ☐ No ☐	**Consent to Use Email Messaging** Yes ☐ No ☐

3. Ethnicity

Which ethnic group do you belong to? ***Tick the space or spaces which apply to you.***

☐ 11 **New Zealand/European**	☐ 33 **Tongan**
☐ 21 **Maori**	☐ 34 **Niuean**
☐ 31 **Samoan**	☐ 43 **Indian**
☐ 32 **Cook Island Maori**	☐ 42 **Chinese**
Other Ethnicity (Please State)	**Iwi**

4. Residential Status

Country of Birth		
If you are not born in NZ are you a NZ Resident? Yes ☐ No ☐	Are you on a working Visa? Yes ☐ No ☐	Visa/Permit sighted Yes ☐ No ☐

5. Next of Kin/Emergency Contact Details

Name	Relationship
Day Phone	Mobile Phone

6. Community Health Details

Community Services Card Yes ☐ No ☐	Card Number	Expiry Date

7. Employer

Name	
Address	
Town/City	Phone
Occupation	

8. Smoking Status

Smoker Yes ☐ No ☐ If yes, would you like support to quit? Yes ☐ No ☐	Ex-Smoker less than 15 months ago ☐	Ex-Smoker more than 15 months ago ☐

9. Transfer of Records

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	Address/Location	

10. Patient Survey

From time to time the Ministry of Health may contact you and ask for your feedback on your experience of care. This provides important information which can be used to improve health services. Participation is voluntary and anonymous.

Patient Survey Contact Details As provided ☐ (or)	Alternative Mobile Phone	Alternative Email Address
No, I do not wish to participate in the Patient Survey ☐		

11. My Declaration of Entitlement and Eligibility

I intend to use this practice as my regular and on-going provider of general practice / GP / health care services.	☐
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 a 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 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 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.	☐

Please list below the Proof of Eligibility documents you will supply with this enrolment form (see Eligibility Criteria in our Enrolment Pack): ……
……
……

12. 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 this practice I will be included in the enrolled population of the Pegasus Health Charitable Ltd PHO (Primary Health Organisation) 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 agree to inform the practice of any changes in my contact details and entitlement and /or eligibility to be enrolled.

I agree that my doctor can access my medical records from other health providers (HealthOne) **Yes** ☐ **No** ☐

I agree to be opted on to the National Immunisation Register (NIR)? **Yes** ☐ **No** ☐

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, Power of Attorney (please provide a copy):		

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This Information Sheet relates to Item 11 on our Enrolment Form

To enrol you as a patient in our practice you will need to provide proof of your eligibility in order to receive government funding to help towards your health care. We are required to sight the documents that confirm your proof of eligibility.

If you wish to enrol with us you will need to provide the following documents:

A New Zealand passport (current or expired)

OR A New Zealand Birth Certificate (or Cook Island, Niue or Tokelau birth certificate) **AND** Two forms of identity proof that you are the person on the birth certificate

OR A New Zealand Certificate of Citizenship
AND Two forms of supporting identity documentation (one needs to have a photograph of the patient)

OR A Descent Registration Certificate
AND Two forms of supporting identity documentation (one needs to have a photograph of the patient)

OR **Evidence you are receiving a Social Security Benefit (e.g.** Community Services Card, Unemployment, Invalids, Sickness Domestic Purposes) **but not Emergency Benefit**
AND Two forms of supporting identity documentation (one needs to have a photograph of the patient)

OR SuperGold Card
AND Two forms of supporting identity documentation (one needs to have a photograph of the patient)

EXAMPLES OF IDENTITY PROOF DOCUMENTS CAN INCLUDE:

* Drivers License
* Employment Contract, Rental Agreement
* Letters addressed to the patient at their current address
* 18+ card
* School/Tertiary ID Card

OBTAINING IDENTITY FOR CHILDREN:

A child under 18 who is in the care and control of an eligible adult who is their legal guardian, parent or in the process of adopting the child or becoming their legal guardian needs to provide:
A Birth Certificate
OR Adoption Papers
OR Guardianship papers, or for a child being adopted: CYF social worker/ NZ Family Court confirmation

If you are enrolling and require a GP consultation on the same day but are unable to provide proof of eligibility/identity as outlined above, then you will be charged as a Casual Patient. Enrolling prior to requiring a consultation means that our doctors will already have access to medical records from your previous doctor and your fees will be cheaper when you do book an appointment.

Information about obtaining a copy of your birth certificate is available on the internet by clicking on: https://www.govt.nz/browse/nz-passports-and-citizenship/proving-and-protecting-your-identity/get-a-birth-certificate/#how-to-apply).
Further information on Criteria and Proof of Eligibility can also be found directly off the Ministry of Health website link: http://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/guide-eligibility-publicly-funded-health-services

MEDICAL INFORMATION

(Please attach a separate sheet of paper if you require extra space on this form)

Surname: …… First Name/s: ……

Date of Birth: ……

ALTERNATIVE EMERGENCY CONTACT - OTHER THAN YOUR PRIME CONTACT LISTED ON ENROLMENT FORM:

Name: …… Relationship to you: …….. phone: ……

NAME OF YOUR REGULAR PHARMACY:
……

PLEASE LIST YOUR REGULAR AND OVER-THE-COUNTER MEDICATIONS: ……

……

……

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?	YES	NO	SPECIFY
Asthma			
Bowel disease or problems			
Other lung or respiratory problems			
Depression and/or Anxiety			
Any other mental health illnesses			
Diabetes			
Heart Disease or problems			
High Blood Pressure			
High Cholesterol			
Joint Disease or problems, e.g. arthritis, rheumatism			
Kidney Disease or problems			
Liver Disease or problems			
ANY OTHER MEDICAL PROBLEMS NOT LISTED ABOVE			

Have you had any operations? If yes, please list : ……..

……

……

Are you allergic to any medications? If yes, please list:

……

……

Are there any illnesses in your family (see list page 1) including cancer? If yes, please list:

……

……

Do you drink alcohol? If yes, what type and how much per week: ……..

……

When was your last Tetanus injection? ……

FEMALES - IF APPLICABLE:

When was your last cervical smear? ……

Have you had an abnormal smear in the past and when? ……

Do you consent to inclusion in the breast screening programme at 45? YES/NO

If over 45 years when was your last mammogram? …….

HOW DID YOU HEAR ABOUT US?

Recommendation Postal flyer Phone Book Sign Web Other

Signed: ……

Print name: …….…… DATE: ……..

Please tick the conditions below that your family members have been diagnosed with:

	Mother	Father	Sibling	Aunt/Uncle	Children	Grandmother	Grandfather
Heart disease	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐
Diabetes type I	☐	☐	☐	☐	☐	☐	☐
Diabetes type II	☐	☐	☐	☐	☐	☐	☐
Cancer (please state type/s)	☐	☐	☐	☐	☐	☐	☐
Thyroid disorders	☐	☐	☐	☐	☐	☐	☐
Reproductive issues	☐	☐	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐	☐	☐
Eating disorders	☐	☐	☐	☐	☐	☐	☐
Autoimmune conditions e.g. multiple sclerosis, lupus, ankylosing spondylitis	☐	☐	☐	☐	☐	☐	☐
Coeliac disease	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Lactose intolerance	☐	☐	☐	☐	☐	☐	☐
Digestive issues	☐	☐	☐	☐	☐	☐	☐
Pregnancy conditions e.g. pre-eclampsia	☐	☐	☐	☐	☐	☐	☐
Depression/Anxiety	☐	☐	☐	☐	☐	☐	☐
Addiction	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐
Dementia (please state type if known)	☐	☐	☐	☐	☐	☐	☐

***Other*_____**

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Dr Bevan Rogers:
MC 10208
EDI: sthsideh

REQUEST FOR PATIENT RECORDS

Date: ……

To: ……

……

……

Dear Practice,

The following patient has asked to enrol at Southside Health Trust.

Please print patient's recall list and either fax to us or place in with their paper notes as they do not transfer via GP2GP.

Please send their patient records to us as soon as possible.

SURNAME: ……

FIRST NAME: ……

D.O.B: …… **NHI** ……

ADDRESS: ……

(PLEASE SEE ATTACHED ENROLMENT FORM)

The patient has also agreed to you informing us of any unpaid debt that they may have with you as having this information is a condition of enrolment with this Medical Centre.

PATIENT SIGNATURE: ……