

	188 St Heliers Bay Road St Heliers Auckland 1071 Phone: 09 585 0188 Fax: 09 585 0199 EDI: glendow www.eastmed.co.nz	SELECT YOUR DOCTOR <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td><input type="checkbox"/> Dr Grace Wong</td><td style="text-align: right;">36410</td></tr> <tr><td><input type="checkbox"/> Dr Jens-Peter Link</td><td style="text-align: right;">43260</td></tr> <tr><td><input type="checkbox"/> Dr Kate Gordon</td><td style="text-align: right;">71786</td></tr> <tr><td>Dr Louise de Candole</td><td style="text-align: right;">59352</td></tr> <tr><td><input type="checkbox"/> Dr Mimi Tanaka</td><td style="text-align: right;">13563</td></tr> <tr><td><input type="checkbox"/> Dr Ryan Tatnell</td><td style="text-align: right;">62140</td></tr> <tr><td><input type="checkbox"/> Dr Simon Garlick</td><td style="text-align: right;">23498</td></tr> <tr><td><input type="checkbox"/> Dr Siva Nachiappan</td><td style="text-align: right;">27161</td></tr> <tr><td>Dr Sue Argent</td><td style="text-align: right;">14537</td></tr> <tr><td><input type="checkbox"/> Dr Susan Smith</td><td style="text-align: right;">15817</td></tr> </table>	<input type="checkbox"/> Dr Grace Wong	36410	<input type="checkbox"/> Dr Jens-Peter Link	43260	<input type="checkbox"/> Dr Kate Gordon	71786	Dr Louise de Candole	59352	<input type="checkbox"/> Dr Mimi Tanaka	13563	<input type="checkbox"/> Dr Ryan Tatnell	62140	<input type="checkbox"/> Dr Simon Garlick	23498	<input type="checkbox"/> Dr Siva Nachiappan	27161	Dr Sue Argent	14537	<input type="checkbox"/> Dr Susan Smith	15817
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ENROLMENT FORM																						

Legal Name	(Title)	Given Name	Other Given Name(s)	Family Name
Preferred Name / Maiden Name		NHI (Office use only)		
Birth Details		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)	Occupation

Usual Residential Address	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
Postal Address <small>(if different from above)</small>	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

Contact Details	Mobile Phone	Home Phone	Email Address
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Emergency Contact	Name	Relationship	Mobile (or other) Phone
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Transfer of Records	<i>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.</i>		
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor and/or Practice Name		Address / Location

Ethnicity Details Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i> Iwi: _____	<input type="radio"/> New Zealand European <input type="radio"/> Maori <input type="radio"/> Samoan <input type="radio"/> Cook Island Maori <input type="radio"/> Tongan <input type="radio"/> Niuean <input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2">Community Services Card</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Day / Month / Year of Expiry</td> <td colspan="3">Card Number</td> </tr> <tr> <td colspan="2">High User Health Card</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Day / Month / Year of Expiry</td> <td colspan="3">Card Number</td> </tr> <tr> <td colspan="2">Do you agree to receive text messages?</td> <td colspan="2">Do you agree to join the patient portal?</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td colspan="2"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td colspan="4">How did you hear about us?</td> </tr> <tr> <td colspan="4"><input type="checkbox"/> Recommendation <input type="checkbox"/> Eastmed Website <input type="checkbox"/> Other _____</td> </tr> <tr> <td colspan="4">Signature</td> </tr> </table>	Community Services Card		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number			High User Health Card		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number			Do you agree to receive text messages?		Do you agree to join the patient portal?		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		How did you hear about us?				<input type="checkbox"/> Recommendation <input type="checkbox"/> Eastmed Website <input type="checkbox"/> Other _____				Signature			
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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)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>

I confirm that, if requested, I can provide 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 this practice, I will be included in the enrolled population with the Primary Health Organisation (PHO) this practice belongs 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	<input type="checkbox"/>	<input type="checkbox"/>
			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 <i>(where signatory is not the enrolling person)</i>	Full Name	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age)		



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Auckland 1071

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MEDICAL HISTORY FORM

Legal Name	(Title)	Given Name	Other Given Name(s)	Family Name
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Current Medical Problems	
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Current Medications	Allergies
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Do you smoke?	<input type="checkbox"/> No (Never) <input type="checkbox"/> No (Ex-smoker) <input type="checkbox"/> Yes	If ticked No (Ex-smoker) or Yes fill → Year Started _____ Year Stopped (if applicable) _____ Type/quantity smoked/day _____
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Alcohol intake?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If ticked yes What/how much do you drink / week _____
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Past History What medical problems have you had in the past? <i>Tick the space or spaces which apply to you</i>	<input type="radio"/> Asthma <input type="radio"/> Diabetes <input type="radio"/> Heart Disease <input type="radio"/> Breast Cancer <input type="radio"/> Bowel Cancer <input type="radio"/> High Blood Pressure <input type="radio"/> Kidney Disease <input type="radio"/> Hepatitis <input type="radio"/> High Cholesterol <input type="radio"/> Melanoma <input type="radio"/> Strokes <input type="radio"/> Operations <input type="radio"/> Other. Please state <input type="text"/>
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Family History What medical problems your family have you had in the past? <i>Tick the space or spaces which apply to you</i>	<input type="radio"/> Asthma <input type="radio"/> Diabetes <input type="radio"/> Heart Disease <input type="radio"/> Breast Cancer <input type="radio"/> Bowel Cancer <input type="radio"/> High Blood Pressure <input type="radio"/> Kidney Disease <input type="radio"/> Hepatitis <input type="radio"/> High Cholesterol <input type="radio"/> Melanoma <input type="radio"/> Strokes <input type="radio"/> Operations <input type="radio"/> Other. Please state <input type="text"/>
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Cervical Smear Women aged 20-70	<input type="checkbox"/> Yes	<input type="checkbox"/> No (Never)	<input type="checkbox"/> I have had abnormal report in the past
Mammogram Women aged 45-69	<input type="checkbox"/> Yes	<input type="checkbox"/> No (Never)	<input type="checkbox"/> I have had abnormal report in the past

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FURTHER INFORMATION																							

Emergency

If you have chest pain, breathless or bleeding inform reception on your arrival.

Website

Our website is <https://eastmed.co.nz/> Please check out the site for more relevant up to date information.

Checking In

Check in with the reception staff on arrival, so they can inform your doctor. If you are waiting more than half an hour, please check with the reception.

Free Wi-Fi

Wi- Fi username is guest@eastmed.co.nz. You can find the current password on the notice boards.

Patient Portals

We are offering patient portals free of charge to our registered patient. You can book appointments and renew prescriptions online. Register at reception if interested.

Enrolment and Funding Status

Present a valid id (passport) on registration. This confirms eligibility for funded health care in New Zealand. If this is not sited or you are not eligible, casual consultation fee apply.

Medical Notes

Your medical notes will be requested from your previous doctors if applicable.

Payment

Pay for your visit on the same day. If payment is not received in 14 days, a \$10 admin fee will apply. Non receipt of payment by 90 days is passed to the debt collectors.

Why Enrol

Please click this excellent link -<https://www.newzealandnow.govt.nz/resources/enrolling-with-your-local-doctor>