Titirangi Medical Centre

Registration checklist

Name

Date of Birth

Would you like to receive text messages?

Y N

Patient history

Are you allergic to any medications?

Y Please state:

N

Date of last tetanus booster?

Which childhood immunisations have you received?

6 weeks 3 months 5 months 15 months 4 years 11 years

Unsure Declined

Do you smoke?

N

Y cigarettes / day

Did you smoke in the past?

N

Y When did you quit?

Do you drink alcohol?

N

Y drinks / week What type?

Date of last mammogram

Annual Two yearly

Date of last smear

Any abnormal history

2 Rangiwai Rd
Titirangi
Waitakere 0604
Auckland

PO Box 60-107
Titirangi
Waitakere 0604
Auckland

Email admin@titirangimc.co.nz
Tel +64 9 817 8069
Fax +64 9 817 8067
Healthlink edi titimedi

NZMC Numbers:
Dr Wong 17501
Dr Conning 36296
Dr Boey 47201
Dr Brown 59863
Dr Teh 64644

Titirangi Medical Centre

Major illness / operation history

Illness / Operation	Date

Patient's family history

Heart disease		Who		What		Age of onset	
Diabetes		Who		What		Age of onset	
Cholesterol		Who		What		Age of onset	

All new patients are required to see the nurse before their first GP appointment in order to collect baseline readings (e.g weight, height, blood pressure etc). The first GP appointment will also be a double appointment (1/2 hour) to ensure that the doctor can review your history.

Signature

Date

Office use only

Date received (electronic)

Date received (hard copy)

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Consent Form for Request of Notes

Date

New TMC GP

NZMC No

Previous Medical Center / GP

Previous Medical Centre Fax

Patient 1 name

Date of Birth

NHI

Signature

Patient 2 name

Date of Birth

NHI

Signature

Patient 3 name

Date of Birth

NHI

Signature

Patient 4 name (If you require more patients please dupicate this form)

Date of Birth

NHI

Signature

To the previous medical practice

The patients listed above have now enrolled as a regular patient with our practice and we would appreciate you forwarding their medical records to us. If they are not registered with your practice please contact us.

Please send notes electronically where possible via (preferably GP2GP). EDI: `titimedi`

Patient consent

By signing this form, I consent to the release of my medical records and/or those of my children under 16 years of age to Titirangi Medical Centre Ltd.

Office use only

Date received (electronic)

Date received (hard copy)

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Electronic Transfer of Notes

Date

To whom it may concern:

Please be advised that nay notes helon on our PMS have been sent electronically via GP2GP or EDI to your healthlink mailbox. Please acknowledge receipt by faxing Titirangi Medical Centre Ltd on 09 817 8067.

Many thanks

Office Manager
Rowena Coleman

Patient 1 name

Date of Birth | NHI | HC Posted

Patient 2 name

Date of Birth | NHI | HC Posted

Patient 3 name

Date of Birth | NHI | HC Posted

Patient 4 name

Date of Birth | NHI | HC Posted

We acknowledge receipt of notes requested

Signature | Date

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Titirangi Medical Centre

Privacy Declaration (optional)

I

Authorise that the doctors or nurses at Titirangi Medical Centre may advise my next of kin:

Name

Relationship

Name

Relationship

Of the results of medical tests and discuss relevant medical issues pertaining to myself.

Signature

Date

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ProCARE	**Titirangi Medical Centre Ltd**	Edi: titimedi Ph: 098178069 Fax: 098178067 PO Box 60-107 Titirangi 0642

Enrolment Form		NHI *(Office use only)*

Name	(Title)	Given Name	Other Given Name(s)	Family Name
Other Name(s) (e.g. maiden name) Please **tick** the name you prefer to be known as				
Birth Details		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender		☐ Male ☐ Female ☐ Gender diverse (please state)		Occupation
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	
Emergency Contact		Name	Relationship	Mobile (or other) Phone
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 and/or Practice Name	Address / Location	

		Do you agree to receive text messages?	☐ Yes	☐ No	
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	**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		
		Do you Smoke?	☐ Yes	☐ No (ex-smoker)	☐ Never

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, 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	☐ 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)		

On signing this enrolment form with TITIRANGI MEDICAL CENTRE LTD I am agreeing with the following terms re payment for services rendered.

Our terms of trade: Payment is expected at the time of contact any amount unpaid will incur a late payment fee of $5.00 per month.

It would assist the practice if you would notify us if you are unable to keep your appointment with at least 2 hours notice, so that it can be offered to someone else. Failure to do this will lead to a charge being made for a missed appointment.