STUDENT HEALTH CENTRE – MANAWATU
THINKHauroa - Your Primary Health Organisation
ENROLMENT FORM

MASSEY UNIVERSITY

GP2GP
Dr Mark Morris
NZMC: 11181
EDI: masseyst

Private Bag 11222, Palmerston North 4442, NZ **T:** +64 6 350 5533 **F:** +64 6 355 7986 **E:** studenthealth.manawatu@massey.ac.nz **W:** www.massey.ac.nz

Please complete all fields	**Student ID:**	NHI *(Office use only)*

Name (Title)	First Name	Middle Name(s)	Family Name	
Other Name(s) (eg. preferred name)				
Birth Details	Day / Month / Year of Birth	Place of Birth	Country of birth	
Gender	☐ Male	☐ Female	☐ Gender diverse (please state)	Preferred Pronoun / 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	

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

- ○ New Zealand European
- ○ Maori
  Iwi_____
- ○ 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

Smoking Status:

☐ No Never Smoked

☐ Ex-Smoker
Date quit:

☐ Current Smoker
Approx. _____ smoked per day

If Current Smoker:
The best advice we can give you for your health and well-being is to quit smoking. Here at the Massey University Health Centre we can help you on your journey to wellness. Please tick if you would like to be contacted for support to quit smoking.

☐ Yes, to be contacted

☐ No, no contact at this time (you may be asked again in the future)

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 Scholarship 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 **Massey University Student Health Centre** I will be included in the enrolled population of THINKHauora and my name, address and other identification details will be included on the Practice, THINKHauora and National Enrolment Service Registers.

I agree for my relevant health information to be shared with other health professionals involved with my health care and well-being.

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 THINKHauora provides along with THINKHauora's name and contact details.

I have read and understand the Use of Health Information Statement (v4.1 dated 6 Nov 2018). The information I have provided on the Enrolment Form will be used to determine eligibility to receive publicly-funded services, as well as for other purposes as stated on the Use of Health Information Statement. 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)		

MEDICAL HISTORY

NHI: Office only

Student ID:	Name:

FAMILY HISTORY

Has any blood relative suffered from any of the following diseases?					
☐ Asthma	☐ Eczema	☐ Diabetes	☐ Heart disease	☐ Tuberculosis	
☐ Cancer	☐ Glaucoma	☐ Epilepsy	☐ High blood pressure	☐ High cholesterol	
☐ Mental illness *(Give detail here if you wish)*					

PERSONAL HISTORY

Have you ever suffered from any of the following?			☐ Asthma	☐ Eczema	☐ Heart disease	☐ Hay Fever
☐ Cancer	☐ Migraine	☐ Diabetes	☐ Mental illness	☐ High cholesterol		☐ Tuberculosis
☐ Epilepsy	☐ Stomach or duodenal		☐ High blood pressure		☐ Tropical Disease (specify)	
☐ Other major illnesses or injuries *(specify)*:						
Have you ever been in hospital as an in-patient?				☐ Yes	☐ No	
If yes, for what illness or operation?						
Are you allergic to any medicines, tablets or injections?	☐ **Yes**	☐ **No**	If yes, to what?			
What medicines or tablets do you take regularly?						
Are you physically disabled?	☐ Yes	☐ No	Please give brief details:			
Immunisations:	Did you have all usual the childhood immunisations?		☐ Yes	☐ No		
Year of last immunisation (if known) against:	Rubella_____	Tetanus_____	Hepatitis_____			
ALCOHOL CONSUMPTION IS AN IMPORTANT FACTOR INFLUENCING HEALTH.						
How many standard drinks would you consume per week:	None	1-4	5-10	More than 10		
For Females Only: Have you had a cervical smear?	☐ No ☐ Yes.	If 'Yes' date or month of smear..... - Results of smear	☐ Normal smear	☐ Abnormal smear		

Further Information