

4. Residential Status:

Place of Birth:

Country of Birth:*

(If NZ is your country of birth, go to Q5)

If you are not born in NZ, are you a NZ resident?

Yes No

Are you on a working Visa?

Yes No

Are you a refugee:

Yes No

Visa/Permit Sighted: (Office Use Only)

Yes No

5. Next of Kin / Emergency Contact Details:

Title:

Family Name :

First Name/s:

Relationship:

Physical Address:

Unit/House No: Street:

Suburb:

Town/City:

Postcode:

Day Phone:

Mobile Phone:

6. Community Health Details:

Community Services Card No:

Expiry Date: / /

Sighted: (Office Use Only) Yes No

High User Health Card No:

Expiry Date: / /

Sighted: (Office Use Only) Yes No

7. Employer:

Name:

Address:

Town/City: Phone:

Occupation:

8. Smoking & Vaping Status:

Smoking & Vaping status is an important factor influencing health. Please tick the space that applies for those aged 15 and over:

Never Smoked

Recently Quit

Ex-Smoker

Currently Smoke

Never Vaped

Recently Quit

Ex-Vaper

Currently Vape

Smoking & Vaping is hugely negative on your good health. In most cases, you will experience the benefits of quitting immediately.

If you currently Smoke, would you like some help to quit? please tick ✓

Declaration of entitlement and eligibility: *

I am entitled to enrol because I am residing permanently in New Zealand. <i>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>	<input type="checkbox"/>
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I am eligible to enrol because:

a	I am a New Zealand citizen <i>(If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below)</i>	<input type="checkbox"/>
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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	<input type="checkbox"/>	Evidence sighted and copy taken <input type="checkbox"/> <i>(Office use only)</i>
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Resident: We require a copy of your passport and Resident Visa
Work Visa: We require a copy of your passport and visa showing you can work in New Zealand for 2 years (previous visas included with consecutive dates)
Citizen: We require a Passport or Birth Certificate with one form of Photo ID.

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 **CENTRAL MEDICAL CENTRE** I will be included in the enrolled population of this practice's Primary Health Organisation (PHO) Midlands Regional Health Network Charitable Trust, 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 Patient Health Information Privacy 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 may use AI tools to support the delivery of healthcare services. Any AI-assisted work is reviewed with human oversight to ensure accuracy and appropriateness. AI is not used for clinical decision-making or judgement. My health information will be handled in accordance with legislative and privacy requirements, and any data processed by AI tools will be managed securely. I understand that I may withdraw my consent to AI-assisted use at any time by notifying the clinician during a consultation.

I **agree** to treat all staff and other patients with kindness and respect, be patient and courteous in all interactions, refrain from any form of abuse, threats, or aggressive behaviour, understand that staff are doing their best to help, and provide honest and accurate information to the practice.

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"/> Self-Signing	<input type="checkbox"/> Authority
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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)		

PATIENT PORTAL FORM

A patient portal is a secure website which can receive and store your health information. The information, for example treatments received or medications, is uploaded from your medical records at the practice.

Patients **must** be 16 years and over to register for the portal and have their own email address.

THE BENEFITS

A patient portal lets patients do things such as:

- Access their medical records, lab results, immunisation records and allergies – 24 hours, 7 days a week (while in NZ)
- Request repeat prescriptions
- Update personal details, including weight, height and blood pressure.
- View recalls and test results
- Share their health information with other health care providers if they choose to
- Book appointments
- Pay accounts online.

REGISTERING FOR THE PORTAL

If you would like to register, please complete the details below:

Full Name as on your enrolment form: _____

Email Address: _____

Signature: _____

Date: _____

Once your enrolment has been entered into our system, you will receive a text and email with your log in details. Please ensure you complete your log in before it expires.



PATIENT HISTORY FORM

Name:

Date of Birth: *Day / Month / Year*

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Medical History:

(please tick ✓ the boxes that apply to you): *

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Other _____ | | |

Do you Smoke? Y N If Yes, how many per day?

Do you Vape? Y N If Yes, how often per day? with nicotine Y N

Do you Drink Alcohol? Y N If Yes, how many standard drinks per week?

Please list any Regular Medication (name, dosage, frequency)

Please list if you have any allergies (medication, foods, environmental)

Please list any previous surgeries (what for and when)

Please list any other medical history we should be aware of



Women's Health:

Are you up to date with your Cervical Screening? Y N Unsure N/A

Have you ever had an abnormal Cervical Smear result? Y N Unsure N/A

Are you up to date with your Mammogram? Y N Unsure N/A

Do you have a family history of breast, ovarian, or uterine cancer? Y N

Men's Health:

Are you up to date with your Prostate Screening? Y N Unsure N/A

Is there any family history of prostate cancer, testicular cancer, or male breast cancer? Y N

Family History:

(please tick ✓ the boxes that apply to you): *

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other (provide details below) |

Signature: _____

Date: _____

Thank you for taking the time to complete this form.
It will enable the Doctors to give you the best possible care.

MEDICAL RECORDS TRANSFER REQUEST FORM

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

In order to receive the best care possible, I agree to **Central Medical Centre** obtaining my medical records from my previous doctor. I also understand that I will be removed from their practice register.

To: _____
(name of previous doctor)

Address: _____
(name of previous GP Practice and address)

Please transfer the medical records for the following people to:

Central Medical Centre

95 Vivian Street, New Plymouth 4310

PH: 06 758 6666

Our Preference is GP2GP

GP2GP: EDI: rallkoen NZMC: 56789

FIRST NAME: Central Medical

LAST NAME: Centre

FAMILY NAME	GIVEN NAMES	DOB	NHI

Signed: _____

Date: _____

Full Name and Relationship: _____
(If signing on behalf of)

PLEASE NOTE: Our Practice no longer processes paper notes, please scan any paper notes the patient may have into their electronic file before transferring to us. It is the responsibility of the Medical Centre holding the records to ensure they are scanned.

Credit Policy & Terms and Conditions of our Medical Centre

Payment for your consultation is required on the day of service.

- Payment is accepted by Cash, Eftpos, Visa or MasterCard.
- Any services not paid on the day, will incur an administration fee of \$15.00; you will have fourteen (14) working days to pay the account in full.
- All our fees are displayed on the notice board.

If you are unable to settle your account on the day of consultation, you must advise reception of this prior to your consultation.

1. Appointments are 15 minutes – if you require longer than this, please advise reception as this will need to be pre-approved by the GP, additional charges will apply.
2. Central Medical Centre has a One problem per Consult policy – this is in place to support our workforce and for your clinical safety.
3. Nurse consults are chargeable.
4. There is a charge for repeat prescriptions. These will only be issued for regular medications, and you have been reviewed for by the doctor within the last 12 months. 72 Hours' notice is required for this service.
5. Central Medical Centre uses the services of a debt collection agency. Any unpaid accounts plus costs in recovering the unpaid account will be the responsibility of the patient.
6. Please advise us of any changes to your contact details or eligibility status.
7. Central Medical Centre will not accept any verbal or physical abuse towards staff. Should an incident occur, it may affect your enrolment with our practice.

I acknowledge that I have read the above and agree with these terms and conditions.

Signed: _____

Date: _____

Full Name: _____

Patient health information privacy statement

Purpose

We respect privacy and confidentiality. The purpose of this document is to explain what information we collect about you and how data gathered by your health provider, as well as by Pinnacle as a primary health organisation and its affiliates, is used in providing health services to you.

To learn what a primary health organisation is and how this practice is connected please see our website <https://pinnacle.health.nz>.

You directly consent to your health information being collected when you sign an enrolment form to register with a practice health provider.

Overview

- Maintaining your trust and privacy is important to us.
- We are bound by law to collect and retain data about the delivery of health services to you.
- We only collect and retain what we need to deliver health services for you and your whānau.
- We only use what we know to improve your health and the health of the community.
- We don't sell the information collected or retained to anyone.
- We only share what we know with people in the health system who we know will look after your information the way we do.
- We look after the information we hold about you and keep it secure.
- Your health record is your health record - you can see it, correct it, and know what we have done with it - just ask.
- From time to time, we may collect information about you from other health providers and health services involved in your care. Examples may include telehealth and virtual providers such as Practice Plus, and other healthcare or after-hours providers.
- If we collect information about you indirectly and you have not already been informed that this may occur, we will, where practicable, notify you. This may be done through your health provider's patient portal or other appropriate means.

What type of information is collected and how it is used?

- Information about you (such as your name, date of birth, gender, address, ethnicity, citizenship, NHI number).
- Information about your health.
- Information about the financial transactions around consultation charges.

The information collected will be:

- used for the delivery of health services by your health provider and Pinnacle
- used by Health New Zealand / Te Whatu Ora to give you a National Health Index (NHI) number or update any changes
- summary information is sent to Pinnacle and Health New Zealand / Te Whatu Ora to support both planning and general practice funding
- may be shared with your consent to specialist, public hospitals, other health providers or after-hours providers (such as Practice Plus) to support your healthcare
- 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.

Our obligations to you

Your privacy and the confidentiality of your information is important to us and a legal requirement.

- Your health information may be reviewed by an auditor either checking on health matters or as part of a financial audit, but only according to the terms and conditions of Section 22G of the Health Act or any subsequent applicable Act.
- You don't have to consent for your health information to be shared, however, withholding it may affect the quality of care you receive. Talk to your health practitioner if you have any concerns.
- Your privacy is our priority. We will keep your information secure and prevent unauthorised access. We work with a range of data sources and platforms, and we constantly evaluate our systems and processes to ensure we are using the latest technologies to increase security.

Right to access and correct

- You have the right to access your health information and have it corrected.
- You don't have to explain why you're requesting the information, but you may be required to provide proof of your identity. If you request a second copy of that information within 12 months, you may have to pay an administration fee to cover reasonable costs to provide that information.
- You have the right to know where your information is kept, who has access rights, and if the system has audit log capability who has viewed or updated your information.
- If asking for your health information to be corrected, your health provider should provide you with reasonable assistance. If your healthcare provider chooses not to change that information, you can have this noted on your file.

Research

Your health information may be used in research approved by an ethics committee or when it has had identifying details removed.

- Research which may directly or indirectly identify you can only be published if the researcher has previously obtained your consent and the study has received ethics approval.
- Under the law, you are not required to give consent to the use of your health information if it's for unpublished research or statistical purposes, or if it's published in a way that doesn't identify you.

Consent options

If you do not agree to have any of your information collected, we may not be able to provide health services to you. Please discuss this with your health provider if you have concerns.

Visiting another practice

If you visit another practice which is not your regular health provider, you will be asked for permission to share information from the visit with your regular health provider.

If you have a High User Health Card or Community Services Card and you visit another health provider which is not your regular practice, they can make a claim for a subsidy, and the health provider you are enrolled with will be informed of the date of that visit. The name of the practice you visited and the reason(s) for the visit will not be disclosed unless you give consent.

Complaints

If you're not happy with the way your health information is collected or used, you can talk to the privacy officer of your health provider about your concerns. By law, all health organisations are required to have a privacy officer.

For specific questions related refer to the privacy section on the Pinnacle Website – <https://www.pinnacle.co.nz/privacy-policy>