Patient Enrolment Form

Student Health and Support

PO Box 85084, Lincoln University, Lincoln 7647
Phone 03 325 3835, Fax 03 325 3881

New Zealand's specialist land-based university

Transfer of notes: GP to GP Preferred EDI lincuniv	MC 13145 Dr. Hamish Dunn	NHI Number (office use only)	Student ID number

Family name:* First name(s):* Male Female

Date of birth:* Day / Month / Year Country of birth (as stated on passport):

Phone number: Cell: Home: Work:

Email address: Occupation:

Physical address:
(Street address or rapid address number required **not** a PO Box or private bag number)

Street:
Suburb:
City:
Post code:*

Postal address: (If different from physical address)
Street/PO Box/Private bag:
Suburb:
City:
Post code:

University address (if relevant):

Emergency contact details:
Name: Relationship: Contact number:

Which ethnic group do you belong to?
Mark the space or spaces that apply to you

New Zealand European
Māori Iwi
Samoan
Cook Island Māori
Tongan
Niuean
Chinese
Indian
Other (such as Dutch, Japanese, Tokelauan)
Please state:

Community Services card:
Yes No Expiry date:
Number:

High user card:
Yes No Expiry date:
Number:

Smoking status:*
Smoker: Ex-smoker: Never smoked:

I intend to use this Practice as my regular and ongoing provider of general practice/GP/First Level primary healthcare services.
I am entitled to enrol because **I am residing permanently in New Zealand**[1] and I am a New Zealand citizen

or meet on of the criteria laid out in the 'Enrolling with General Practice Guide'.
State which letter:

By enroling with this Practice I confirm I have read and will abide with the conditions stated below.
I confirm that if requested I can provide proof of my eligibility.
I agree to inform the Practice of any changes in my eligibility.
I understand that by enrolling with the Practice I will be enrolled with Primary Health Organisation (PHO) this Practice belongs to and my name, address and other identification details will be included on both the Practice and the PHO Enrolment register.
I understand that if I visit another 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 with the PHO and their contact details.
I have read and I agree with the Health Information Privacy Statement.

Signed:* Full Name(Print): Date:

Relationship if not person shown on the form i.e. parent or caregiver if you are under 16 years of age or legally authorised representative e.g. attorney, if the person is unable to consent on their own behalf.

Transfer of Records from another Practice:
In order to get the best coordinated healthcare, I ask this Practice to request that my medical records are transferred from my previous Practice. I also understand that I will be removed from the register of my previous Practice.

Yes No N/A Previous Practice:

* Fields with an asterisk must be filled in.
Note 1: The definition residing permanently in New Zealand, means that you intend to be resident in New Zealand for at least 183 days in the 183 days in the next 12 months.

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Health Status

Please fill in the following details to the best of your knowledge.
This information helps us to provide better care for you.

1. **Current medication**

2. **Allergies**

   Yes No

   If yes, type of reaction

   Drug allergy if known:

3. **Health history**

   Exercise times a week

   Alcohol Yes No If yes, how many standard drinks per week?

4. **Immunisations**

   Have you had all childhood vaccinations Yes No Unsure

   Female to answer
   Have you completed the course of Gardisil/HPV/Cervical Cancer Vaccine? Yes No Unsure

5. **List significant medical history, past and present.** Include illnesses, accidents, injuries, operations and procedures.

After completing this form either

A. **Print it, sign it and post** to
Student Health, PO Box 85084, Lincoln University, Lincoln 7674, Christchurch or

B. **Print it, sign it, scan the document, then email** it to healthsupport@lincoln.ac.nz