PATIENT ENROLMENT FORM

Address: 62 Aranui Road, Mapua 7005
Phone: 03 540 2211
EDI: mapuahct

Provider name:	**NZMC:**	**NHI:**

Legal Name	Title	Given Name	Middle Name(s)	Family Name
Other Name		Preferred Name (s)		Other Family Name (e.g. maiden name)
Birth Details		Day / Month / Year of Birth	Place of Birth	Country of birth
Sex at birth	☐ Male ☐ Female	**Gender you would like to be identified as**	☐ Male ☐ Female ☐ Gender Diverse (please specify)	

Usual Residential Address	House Number and Street Name	Suburb	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb	Town / City and Postcode

Contact Details	Mobile Phone	Home Phone	Email Address	
Employment Details	Occupation		Employer	Work Phone
Emergency Contact	Name		Relationship	Mobile (or other) Phone
Do you consent to receive communication from this practice via text messaging?			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 – Iwi /Tribe……
- ○ Samoan
- ○ Cook Island Maori
- ○ Tongan
- ○ Niuen
- ○ Chinese
- ○ Indian
- ○ Other European (Please state) ……
- ○ Other (such as Dutch, Japanese, Tokelauan).

Please state ……

SMOKING STATUS: Do you smoke tobacco?
(Please tick one) YES ☐ NO ☐

Past Smoker *(Given up more than 12 months ago)* ☐

TERMS OF TRADE

Payment is due at the time of your consultation unless a prior arrangement has been made.
An administration fee of $10 will be added to your account if payment is not received on the day.
Unpaid accounts will be referred to a Debt Collection Agency after 90 days. An additional fee and all collection costs will be added at time of referral **(Please note that this action will create extra costs for you).**
Visitors/Casual patients – no credit is available.

Transfer of Records ***Signature required***	*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 as I am only able to be enrolled at one practice at a time in New Zealand*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Signature of consent for transfer of records	

Patient Survey	*From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.*		
Patient Survey Contact Details	☐ As provided **(or)**	Alternative Mobile Phone	Alternative Email Address
	☐ No, I do not wish to participate in the Patient Survey		

My declaration of entitlement and eligibility

I intend to use this practice as my regular and on-going provider of general practice / GP / health care services.	☐
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 entitlement 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 current work visa/permit and can show that I am legally able to be in New Zealand for at least 2 years (previous visa/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 and 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	☐

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 ongoing provider of general practice/GP/health care services.

I **understand** that by enrolling with this practice I will be included in the enrolled population of this practices Primary Health Organisation (PHO) Nelson Bays Primary Health Organisation this practice is contracted 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 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)		

OFFICE USE ONLY:		
Photo ID:		
ID:		
ID:		Staff Initial