PATIENT ENROLMENT FORM

(Family members over the age of 16 to fill out their own form)

Remuera Medical Centre
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NHI:

Title	Surname	First Names	Preferred name/ Alias	Date of Birth	M/ F

RESIDENTIAL ADDRESS			
Street:			
Suburb:			Postal code:
City			PO Box:
Phone:		Work:	Mobile:
Email:			
Occupation:			
Place of Birth: City:			Country

EMERGENCY CONTACT: Name of person	Phone number	Relationship to you

Ethnicity – which ethnic group do you belong to: (you may select up to three ethnicities)

☐ 11 NZ European	☐ 33 Tongan	☐ 41 South East Asian	☐ 51 Middle Eastern
☐ 12 Other European	☐ 34 Niuean	☐ 42 Chinese	☐ 52 Latin American
☐ 21 NZ Maori Iwi: _______________	☐ 35 Tokelauan	☐ 43 Indian	☐ 53 African
☐ 31 Samoan	☐ 36 Fijian	☐ 44 Other Asian	☐ 54 Other __________________
☐ 32 Cook Island Maori	☐ 37 Other Pacific		

Community Services Card: ❑Yes ❑No	Card No:
	Expiry date:
High User Health Card: ❑Yes ❑No	Card No:
	Expiry date:
Do you smoke? ❑Yes ❑Never ❑ Ex Smoker	

TRANSFER OF RECORDS (new patients only)

Do you authorise transfer of your medical records from your previous doctor ❑Yes ❑No

I understand that my/our names will be removed from the register of my previous general practice.

Name of former Doctor and or Practice ______________________________

Address: ____

Signature: ___________________________________ Date: ___________________

I intend to use Remuera Medical Centre as my regular and ongoing provider of general practice/GP/First Level primary healthcare services.

I am eligible to enrol because **I am residing permanently in New Zealand**. **I live in New Zealand** and meet one of the following eligibility statements:

- ❑ a) I am a New Zealand citizen (including those from Cook Islands, Niue or Tokelau) **OR**
- ❑ b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) **OR**
- ❑ 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 **OR**
- ❑ 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) **OR**
- ❑ e) I am an interim visa hold who is eligible immediately before my interim visa started **OR**
- ❑ 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 **OR**
- ❑ 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**
- ❑ h) I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder **OR**
- ❑ i) I am a New Zealand Aid Programme student studying in New Zealand and receiving Official Development Assistance funding (or their partner or child under 18 years old) **OR**
- ❑ j) I am participating in the Ministry of Education Foreign language Teaching Assistantship scheme **OR**
- ❑ k) I am a Commonwealth Scholarship holder studying in New Zealand 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.

I wish to enrol/re-enrol with this general practice	**❑Yes ❑No**

I understand that:

- This provider is a member of a Primary Health Organisation (PHO) and I have been informed of the implications of enrolment with this PHO.
- I cannot enrol with more than one practice at the same time.
- This practice is funded on the basis of its enrolled register and information on this form will be sent to the Health Funding Organisation.
- I agree to the practice sharing my health information with other health providers involved in my healthcare.
- My information may be used for practice screening & recall programmes, and practice quality activities and audit.
- I have read this document and understand and agree that I am now an enrolled patient of this practice.

❑ I have been given and read the Health Information Privacy Statement.

Signature of patient:	Print Name:	Date:
OR signed by authority	Relationship to patient:	