HILLCREST MEDICAL & TAMAHERE MEDICAL CENTRES

PATIENT ENROLMENT FORM

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

***Must be completed** NHI: (Office Use Only)*

1. Personal Details:

Title: **Family Name:*** **First Name/s:***

Preferred Name: **Other name/s known by and/or Maiden name:**

Date of Birth:* **Gender:* At birth** Please Tick ✓ **M** **F** **Gender you would like to be identified as:** Please tick ✓ or state **M** **F** **Gender diverse**

2. Contact Details:

Physical Address:*

Unit/House No: **Street:** **Suburb:**

Town/City: **Postcode:**

Work Phone: 0 **Home Phone:** 0 **Mobile Phone:** 0

Email Address:

Postal Address: (If different from Physical Address)

PO Box/Unit/ House No: **Street:** **Suburb/Rural Delivery:**

Town/City: **Postcode:**

Preferred Contact Methods: Please Tick ✓

Secure Email **Text** **Landline** **Cell Phone** **Post** **SMS: Yes / No** **Account Holder Yes / No**

3. Ethnicity*:

WHICH ETHNIC GROUP DO YOU BELONG TO? (YOU MAY SELECT UP TO THREE ETHNICITIES):

NZ European/Pakeha	11	Samoan	31	Cook Island Maori	32
Maori (please state iwi)	21	Tongan	33	Niuean	34
Other European	12	Indian	43	Chinese	42
Middle Eastern	51	South East Asian	41	Other Asian	44
Latin American	52	African	53	Declined	95

Other Please state

4. Community Health Details:

Community Services Card No: | **Expiry Date** | **High User Health Card No:** | **Expiry Date**

5. Residential Status:

Place of Birth:* | ***Country of Birth:****

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 ☐

Date of Arrival in New Zealand _____

6. Employer:

Name:

Address:

Town/City: | **Phone:**

Occupation:

7. 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: 0 | **Mobile Phone:** 0

8. Patient Smoking Status:

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

☐ Never smoked ☐ Currently a smoker ☐ Recently quit ☐ Ex-smoker (over 1 year)

Smoking 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? ☐ Yes ☐ No

MY DECLARATION OF ENTITLEMENT AND ELIGIBILITY

I am entitled to enrol because I am residing permanently in New Zealand[1] and meet one of the following eligibility criteria: The definition of residing in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 mths.

I confirm that, if requested, I can provide proof of my eligibility. Yes / No

		Please circle one
a)	I am a New Zealand citizen **OR**	Yes / No
b)	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010	Yes / No
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	Yes / No
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)	Yes / No
e)	I am an interim visa holder who was eligible immediately before my interim visa started	Yes / No
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	Yes / No
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	Yes / No
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	Yes / No
i)	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)	Yes / No
j)	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	Yes / No
k)	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund.	Yes / No

MY AGREEMENT TO THE ENROLMENT PROCESS:

(NB Parent or caregiver to sign if you are under 16 years)

I intend to use Hillcrest Medical Centre as my regular and ongoing provider of general practice / GP / health care services.

I understand that by enrolling with this Hillcrest Medical Centre I will be included in the enrolled population of Midlands Regional Health Network Charitable Trust, and my name address and other identification details will be included on the Practice, PHO and the National Enrolment Services 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 (Midlands Regional Health Network Charitable Trust), and their 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 compare with other government agencies, but only when permitted under the Privacy Act.

I understand that my health team may share my relevant health information with other health professionals who are directly involved in my care, including accessing my clinical information held with other health professionals.

I understand that Hillcrest Medical *staff may sometimes access my notes for administration purposes***.**

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.

I agree that I may be charged $20 minimum for an appointment if I fail to notify the practice in advance that I am unable to attend that appointment.

	/ / Day Month Year
SIGNATURE*	**DATE***

OR signed by AUTHORITY[2] An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Full Name of Authority:	Contact Phone Number:	Relationship:
Address:	Signature of Authority:	/ / Day Month Year