Registered Patient Enrolment Form

NHI Number

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Title (circle)	Mr Mrs Miss Ms Dr		**Assigned Sex (Circle):** Male Female **Preferred Gender:** _____ **Preferred Pronoun:** _____	**Yes**	**No**	**N/A**
Legal Name	**First Name:** **Preferred First Name:**	**Middle Name(s):**	**Surname:**	**Yes**	**No**	**N/A**
Birth Details	**Day / Month / Year**	**Place of Birth**	**Country of Birth**	**Yes**	**No**	**N/A**
Contact Details	**Landline / Mobile:**	**Email Address:**		**Yes**	**No**	**N/A**
Usual Residential Address	**House (or RAPID) Number and Street Name or Rural Delivery**		**Town / City and Postcode**	**Yes**	**No**	**N/A**
Postal Address (If different from above)	**PO Box**	**Suburb / Rural Delivery**	**Town / City and Postcode**	**Yes**	**No**	**N/A**
Occupation	**Occupation:** **Name of Employer:** **Address:**			**Yes**	**No**	**N/A**

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Emergency Contact	**Full Name**	**Relationship**	**Address**	**Yes**	**No**	**N/A**
	Mobile Phone	**Email Address**		**Yes**	**No**	**N/A**

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Transfer of Records: *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. (Circle):*

Yes, please transfer my records **Previous Doctors Name/ Practice Name:** **Location / Address:**	**No**	**Not Applicable:**	**Yes**	**No**	**N/A**

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Which ethnic group do you belong to? Mark the space or spaces which apply to you				**Yes**	**No**	**N/A**
⬭	New Zealand European	⬭	Māori			
⬭	Samoan	⬭	Cook Island Māori			
⬭	Tongan	⬭	Niuean			
⬭	Chinese	⬭	Indian			
Other such as DUTCH, JAPANESE, TOKELAUAN						

Smoking Status (Circle) **Never Smoked #1371** **Current Smoker #137R** **Ex- Smoker #137S** **Months/Years Quit _____**	**Yes**	**No**	**N/A**
I would like help to quit: Yes / No	**Yes**	**No**	**N/A**

National Breast and Cervical Screening Programmes I understand this practice participates in National Screening Programmes and that I may be enrolled in any relevant Programmes e.g., **Cervical or Breast Screening**, unless I chose not to (circle): **Yes / No**	**Yes**	**No**	**N/A**

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. (Circle) **Patient Survey Contact Details:** As provided above **OR** I do not wish to participate	**Yes**	**No**	**N/A**

My declaration of entitlement and eligibility

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)*	☐

OR

B) I am entitled to enrol because I am residing permanently in New Zealand. (*Please provide proof of eligibility)* *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*	☐

If you are **not a New Zealand citizen,** please tick which entitlement criteria applies to you (c–k) below:

C)	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	☐
D)	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	☐

E)	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)	☐
F)	I am an interim visa holder who was eligible immediately before my interim visa started	☐
G)	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	☐
H)	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	☐
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)	☐
J)	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	☐
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	☐

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Proof of Eligibility – Please attach proof eligibility as follows:		**Evidence scanned**		
• Photo ID (*e.g., Passport or Drivers Licence or Birth Certificate)* • Copy of Working Visa* (*only required if you are not a NZ Citizen or Resident)* **Your visa must be valid for 2 years or more from the date of arrival into NZ.*	☐	**Yes**	**No**	**NA**

My agreement to the enrolment process

NB Parent or Caregiver to sign if as an authority if you are under 16 years old

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 Twizel Medical Centre, I will be included in the enrolled population of South Canterbury District Health Board (SCDHB) Primary & Community Care Primary Health Organisation (PHO), 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 understand that my practice will have access to My Shared Care Records (HealthOne) from other Health Providers.

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.

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Signature	**Date**	**Self-Signing** ☐	**Authority to Sign** ☐	**Yes**	**No**	**NA**

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)		

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	Date Received	Date Entered/Scanned	Entered By
Enrolment Form Received			
Patient Enrolled in MedTech ***Key Items to check:*** • ***GMS = Adult or Child*** • ***Provider Details*** • ***Account Group = Patient or CAS*** • ***Ethnicity*** • ***Visa Dates*** • ***Family Tree Registered***			
NHI Number Allocated			
E-Notes arrived (circle) EDI or GP2GP			
Paper notes arrived			
Paper notes scanned to Patient File			
Enrolment Form Scanned to Patient File			
Paper Enrolment Form filed in folders			