Hamilton East Medical Centre
PATIENT ENROLMENT FORM

Anyone over age of 16 years old must complete their own enrolment form

Office Use Only				
Received		**Checked**		**Office Use Only**
Initial	Date	Initial	Date	**NHI:**

***MUST** be completed:*

Personal Details:

Legal Name:*

Title: **Family Name:*** **First Name:*** **Other Given Name:***

Preferred Name: **Previous name/s:**

Date of Birth:* **Sex (at birth):*** **Gender you would like to be identified as:*** **(please tick✓)**

Day Month Year — Male* Female* — Male* Female*

Contact Details:

Usual Residential 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 Usual Residential 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:** ☐

Consent to use TEXT or email notifications: ☐ **Yes** ☐ **No**

Ethnicity and Residential Details:

Which ethnic group(s) do you belong to? (Tick the space or spaces which apply to you)

- ☐ 11 **New Zealand European**
- ☐ 21 **Maori** Iwi: _____
- ☐ 31 **Samoan**
- ☐ 32 **Cook Island Maori**
- ☐ 33 **Tongan**
- ☐ 34 **Niuean**
- ☐ 42 **Chinese**
- ☐ 43 **Indian**
- ☐ **Other** (such as Dutch, Japanese, Tokelauan)
- ☐ **If not listed above please state**: _____

Country of Birth: _____ **Place of Birth:** _____

If you are not born in New Zealand are you a New Zealand resident?
Yes ☐ **No** ☐

Are you a refugee?
Yes ☐ **No** ☐

Are you on a working visa?
Yes ☐ **No** ☐

(Office Use Only)
Visa/Permit Sighted
Yes / No
Circle the above

Smoking Status:

If you are aged 15 and over please tick the space that applies for you:

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

If you currently smoke, would you like some help to quit?

Yes ☐ **No** ☐

Smoking is hugely negative on your good health. In most cases, you will experience the benefits of quitting immediately

Emergency Contact /Next of Kin:

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

Physical Address:

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

Town/City: **Postcode:**

Work Phone: 0

Home Phone: 0

Mobile Phone: 0

Community Services Information:

Community Services Card No: *(not client number)*	**Expiry Date:** ***Day / Month / Year***	*Sighted (Office Use Only)* *Yes / No (circle the above)*
High User Card No:	**Expiry Date:** ***Day / Month / Year***	*Sighted (Office Use Only)* *Yes / No (circle the above)*

Employer / Occupation Details:

Employers Name:	**Phone:**
Address:	**Occupation:**

Signed Authority:

My declaration of entitlement and eligibility: (please carefully read & tick ✓)

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 <u>not</u> a New Zealand citizen please tick which eligibility 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 work visa/permit and can show that I am able to be in New Zealand for at least 2 years (previous 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 **OR** in the 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	☐

(Office use only) *Evidence sighted*	*Yes / No*

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 on-going provider of general practice / GP / health care services.

I understand that by enrolling with Hamilton East Medical Centre I will be included in the enrolled population of The Midlands Regional Health Network Charitable Trust, 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 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.

<u>SELF SIGNING: *</u>

Signature*	**Date**

Or **<u>AUTHORITY</u>** ***(an authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf, e.g. parent of a child under 16 years of age)***

Full name:*	**Relationship:***	**Phone:***

Signature*	**Date***