PATIENT ENROLMENT FORM

ProCARE

Practice name* HOBSONVILLE MEDICAL CENTRE
Phone number 09 4168712
Address 42 SUNCREST DR, HOBSONVILLE, AUCKLAND 0618
EDI number hobsonvm
Fax number 09 4168712

NHI*

Title* Mr Mrs Ms Miss Dr	Surname*	First name(s)*
Preferred name		Other names known by (e.g. maiden name)
Gender* Male ☐ Female ☐	Date of birth* day	month year

Physical address* Street or rapid (rural) no.	Name of street		**Place of birth*** Suburb
Suburb	City/town	Postcode	City/town
Country			Country

Postal address

Contact details

Day phone	Night phone
Cellphone	email
Occupation	Do you agree to receive text messages? Yes ☐ No ☐

Emergency contact

Name	Relationship	Phone

Private health insurer:

Community Services Card Yes ☐ No ☐	Card number Expiry date
High User Health Card Yes ☐ No ☐	Card number Expiry date

Which ethnic group do you belong to? Mark the space or spaces which apply to you

New Zealand European	
Maori	
Samoan	
Cook Islands Maori	
Tongan	
Niuean	
Chinese	
Indian	
Other such as DUTCH, JAPANESE, TOKELAUAN. Please state:	

Do you smoke? Yes ☐ No (ex smoker) ☐ Never ☐

Transfer of records: for continuity of my care, I agree to the practices transferring my records from my previous doctor. I also understand that I will be removed from their practice register.

Yes ☐ No ☐ Doctor's name

Address/location	**Signature**	**Date**

Dependants listed on this form will also be enrolled in the PHO as long as I am legally entitled to sign on their behalf (see below)
Authorised representatives can enrol dependants. In the case of a dependant child under 16 years old, the process can be completed by a parent or caregiver who is the legal guardian or who has custody. It is recommended that each child is enrolled on his/her own form.

NHI*	First names*	Family name*	Gender*	Ethnicity/ ethnicities*	Date of birth*	Country of birth*

*** Mandatory to complete**

PLEASE TURN OVER TO COMPLETE THIS FORM

PRO_07_13_001

PATIENT ENROLMENT FORM (cont.)

ProCARE

ENROLMENT IN THE PRACTICE / PRIMARY HEALTH ORGANISATION (PHO)

I intend to use _____ 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:***** (please tick)

☐ 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 two 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 two years (previous permits included) **OR**

☐ e. I am an interim visa holder 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.

MY AGREEMENT TO THE ENROLMENT PROCESS* **NB Parent or caregiver to sign if you are under 16 years**

I choose to enrol with this practice as my regular and on going provider of general practice / GP / First Level primary healthcare services.

I understand that by enrolling with this practice I will be enrolled with the Primary Health Organisation (PHO) this practice belongs to, and my name, address and other identification details will be included on both the Practice and the PHO Enrolment Register.

I understand that if I visit another 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 with the PHO, and their contact details.

☐ **I have read and I agree** with the Health Information Privacy Statement in accompanying PHO information.

I agree to inform the practice of any changes in my eligibility.

Signature* *Signature of patient enroling*		**Date*** day month year
OR signed by authority* **		
Full name of authority	**Contact phone number**	**Relationship**
Address	**Signature of authority**	**Date** day month year
Detail the basis of authority (e.g. parent of a child under 16):		

*** Mandatory to complete**
****The definition of residing in NZ is that you intend to be resident in NZ for at least 183 days in the next 12 months**
***** An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.**