Whangamata Medical Centre

Pinnacle Midlands Health Network

PATIENT ENROLMENT FORM

Fields with * are compulsory	*Anyone over age of 16 years must complete their own enrolment form*	**NHI** *(Office use only)*

Title	*	**Family Name**	*	**First Name/s**	*
Preferred Name:		Other Name/s: *(eg: Maiden Name)*			

Gender *(please tick)* * you would like to be identified as ☐ Male ☐ Female ☐ Gender Diverse

Sex at Birth (if different) * ☐ Male ☐ Female

Ethnicity Details *
Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you

- ☐ 11 New Zealand European
- ☐ 31 Samoan
- ☐ 32 Cook Island Maori
- ☐ 34 Niuean
- ☐ Other (such as Dutch, Japanese, Tokelauan)
- ☐ 21 Maori - Iwi ____________________________
- ☐ 33 Tongan
- ☐ 42 Chinese
- ☐ 43 Indian
- Please state: ____________________

Date of Birth	* Day / Month / Year	* Place of Birth	* Country of birth
Permanent Address	* Unit / House no.	* Street Name	
	* Suburb	* Town City	

Cell Phone Number	*	Email Address	*
	I consent to receive text messages. ☐ Yes ☐ No		*I consent to received emails* ☐ Yes ☐ No
Home Phone Number	*	Work Number	*

Community Services Card ☐ Yes ☐ No	Expiry Day / Month / Year	Card Number
High User Health Card ☐ Yes ☐ No	Expiry Day / Month / Year	Card Number

Postal Address: *If different from Permanent Address*	Unit / House / PO Box no	Street Name
	Suburb	Town / City

Emergency Contact/NOK		**Relationship**	*
Name	*	**Contact No:**	*

* **Alcohol Consumption**	Do you drink Alcohol? ☐ Yes ☐ No		* **Smoking is an important factor influencing health** If you are aged 15 and over, please tick the space that applies for you		Currently smoke
					Recently quit
If Yes, what is your average intake?		1 – 5 units per week	Smoking is hugely negative on your good health. In most cases, you will experience the benefits of quitting immediately.		Never smoked
		6 – 10 units per week			Ex-smoker (over 1 year)
***A unit is one standard drink*		11 – 15 units per week	**If you currently smoke,** would you like some help to quit?		Yes
		15 or more units per week			No

Occupation	*		
Employer Name	*	**Contact No:**	*
Address	*		

* **My Indici** If you are over 16 years of age, we suggest your register with My Indici. Please supply your individual email address (can not be used by any other family member) for registration purposes.

I wish to join My Indici (please tick) ☐ Email for My Indici: ____________________________

Preferred Pharmacy: ____

Residential Status:	* If not born in NZ are you a NZ resident? ☐ Yes ☐ No	* Are you on a working visa? ☐ Yes ☐ No Expiry Date:	* Are you a Refugee? ☐ Yes ☐ No

*My declaration of entitlement and eligibility *(please tick as appropriate)*

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 **not 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		Evidence sighted (*Office use only*)

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 Whangamata 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.

I agree that this Practice is entitled to charge a fee for health services provided and that those fees are expected to be paid on the day the service is provided.
Any arrangement to defer payment must be authorised by the Office Manager.

Signatory Details	* **Signature**	* **Day / Month / Year**	☐ **Self Signing**	☐ **Authority**

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)		