ENROLMENT FORM

*** NHI** *(Office use only)*

newlands medical centre

15 Batchelor Street, PO Box 26-062
Newlands, Wellington 6037
Phone 04 478 9858 Fax 04 478 9852
newlands@newlandsmedical.co.nz
EDI: nulandmc Dr Tony Jackson NZMC 20430

*** *MUST be completed***

Legal Name *	Mr Mrs Ms Miss Dr Other	Surname/Family Name	First/Given Name	
		Middle Name(s)	Preferred Name	Previous Surname
Birth Details *		Day / Month / Year of Birth	Place of Birth	Country of Birth
Gender *	☐ Male ☐ Female ☐ Gender diverse (please state)		Preferred Pronoun:	

Usual Residential Address *	House Number and Street Name	Suburb	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb	Town / City and Postcode
Contact Details *	Work Phone / Home Phone	Mobile Phone	
	Email Address		

Next Of Kin / Emergency Contact *	Name	Relationship	Mobile (or other) Phone
	Address		

Community Services Card	☐ Yes	☐ No

	Which Ethnic group do you belong to? * Mark the space or spaces which apply to you	✓
21	Maori	
34	Niuean	
33	Tongan	
32	Cook Island Maori	
31	Samoan	
43	Indian	
42	Chinese	
11	New Zealand European	
	Other (i.e. Dutch, Japanese, Tokelauan)	

Consent to use text messaging	☐ Yes ☐ No
Consent to use email We will not email you clinical information.	☐ Yes ☐ No
New to enrolling in New Zealand?	☐ Yes ☐ No
If yes, can you provide a copy of your immunisation records?	☐ Yes (see attached) ☐ Yes (will provide separately) ☐ No ☐ N/A
Main Language If not English, interpreter required? Y / N	

Transfer of Records Authority *	*In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I understand I will be removed from their practice register, as I am only able to be enrolled at one practice at a time in NZ.*	
	☐ Yes - please request transfer of my records ☐ No ☐ Not Applicable	Previous Doctor and/or Practice Name
	Signature Day / Month / Year	Previous Practice Address / Location

My declaration of entitlement and eligibility ** MUST be completed*

*	**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*	**Y☐ N☐**

* **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 24 months (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 i.e. Passport/Birth Certificate, permits/visas	☐	Evidence copied (*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 / First Level Primary Health care services.

I understand that by enrolling with **Newlands Medical Centre Limited** I will be included in the enrolled population of **Tu Ora Compass Health** 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 read the Health Information Privacy Statement and acknowledge that the information I have provided on the Enrolment Form will be used to determine eligibility to receive publicly-funded services. I also acknowledge that my information may be shared with other agencies, but only when permitted under the Privacy Act and Health Information Privacy Code.

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 understand that Newlands Medical Centre Limited may charge for missed appointments.

I understand that payment is expected at the time of the visit. An administration fee will be added to unpaid accounts and any debt collection costs incurred will be my responsibility.

*	**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)		

How did you hear about us? Family/Friend recommendation ☐ Internet ☐ Printed advertisement/flyer ☐

Photo ID Copied	Processed	Checked	Enrolled in NES	Fax Date

***Field above for Office Use ONLY**