




ENROLMENT FORM

New Re-enrol

* NHI (Office use only)

	15 Batchelor Street, PO Box 26-062 Newlands, Wellington 6037 Phone 04 478 9858 newlands@newlandsmedical.co.nz EDI: nulandmc Dr Tony Jackson NZMC 20430
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*** 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 *	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Another gender (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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Portal - MyIndici If aged 16yrs or over and have an email address, you will automatically be registered for Portal access.	<input type="checkbox"/> Opt out/decline
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Which Ethnic group do you belong to? * Mark the space or spaces which apply to you	<input checked="" type="checkbox"/>
New Zealand European	
Māori	
Samoan	
Cook Island Māori	
Tongan	
Niuean	
Chinese	
Indian	
Other (i.e. Dutch, Japanese, Tokelauan)	

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

Transfer of Records Authority *	<i>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.</i>	
	<input type="checkbox"/> Yes - please request transfer of my records <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	Previous Doctor and/or Practice Name
	Signature	Day / Month / Year
	Previous Practice Address / Location	

Please note - it can take up to 10 working days for your notes to transfer to us. Unless urgent, please defer your first appointment to allow for this.

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 <i>(If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below)</i>	<input type="checkbox"/>
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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)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>

* I confirm that, if requested, I can provide proof of my eligibility i.e. Passport/Birth Certificate, permits/visas	<input type="checkbox"/>	Evidence copied <i>(Office use only)</i>
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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	<input type="checkbox"/>	<input type="checkbox"/>
			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 <i>(where signatory is not the enrolling person)</i>	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	Emailed Date
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*Field above for Office Use ONLY