Newtown Medical Centre

ENROLMENT FORM

Newtown Medical Centre
33 Rintoul Street, Newtown Wellington 6021
Phone: (04) 389 9955 Fax: (04) 389 9828

NHI (Office use only)

Name	**Title**	**First Name(s)**		**Family Name**			
Other Names		**Preferred First Name(s)**		**Any other names know by (e.g. maiden name)**			
Birth Details		**Place of Birth**	**Country of Birth**	**Day / Month / Year of Birth**	**Male**	**Female**	**Other**

Residential Address	**House number and street name**	**Suburb**	**City and Postcode**
Postal Address (if different from above)	**House number and street name**	**Suburb**	**City and Postcode**

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

Smoking Status	☐ **Never Smoked**	☐ **Current Smoker**	☐ **Ex-Smoker**

Contact Details	**Mobile Phone**	**Home Phone**	**Email Address**	
Emergency Contact	**Name**		**Relationship**	**Phone**

Ethnicity Details Which ethnic groups do you belong to?	NZ European	☐	Chinese	☐	South East Asian	☐
	Maori	☐	Indian	☐	Other Asian	☐
	Samoan	☐	Other European	☐	African	☐
	Cook Isl. Maori	☐	Tokelauan	☐	Middle Eastern	☐
	Tongan	☐	Fijian	☐	Latin American	☐
	Niuean	☐	Other Pacific Isl.	☐	Other	☐
Occupation	Current Occupation					

(Office use only)

Where possible we prefer to receive notes via GP2GP transfer

EDI: **newtown**
Our postal address is:

PO Box 7141
Wellington 6242

Jill Shepherd	**12726**
Alistair Hayworth	**16773**
Stephen Kuzmich	**17323**
I-Pen Hsu	**36475**
Simon Morley	**77305**
James Parsons	**59523**
Lauren Richardson	**80123**

Transfer of Records *For children under 12, please present vaccination history to reception*	*In order to get the best care possible, I agree to the practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register.*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Address/Location	

My declaration of entitlement and eligibility to enrol

I intend to use this practice as my regular and on-going provider of general practice/health care services	
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 a 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 entitlement 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 is a NZ citizen or meets one criterion in clauses a-f above	
h	I am a NZ Aid Programme student studying in NZ and receiving Official Development Assistance funding (or my partner/child under 18 years old is)	
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	

My agreement to the enrolment process

NB. Parent or Caregiver to sign if you are under 16 years

I understand that by enrolling with this practice I will be included in the enrolled population of the Primary Health Organisation (PHO) this practice is contracted to, 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 Health Information Privacy Statement (attached).

I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

I consent to the practice team contacting me via text message to the mobile phone number I have given	☐ **Yes**	☐ **No**

Signatory Details	Signature	Day / Month / Year of Signing	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)		