



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	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number
High User Health Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number

Smoking Status	<input type="checkbox"/> Never Smoked	<input type="checkbox"/> Current Smoker	<input type="checkbox"/> Ex-Smoker
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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	(Office use only) Where possible we prefer to receive notes via GP2GP transfer EDI: newtown Our postal address is: PO Box 7141 Wellington 6242	Don Simmers 9111
	Maori	Indian	Other Asian		Jill Shepherd 12726
	Samoan	Other European	African		Alistair Hayworth 16773
	Cook Isl. Maori	Tokelauan	Middle Eastern		Stephen Kuzmich 17323
	Tongan	Fijian	Latin American		Terry Quirke 36089
	Niuean	Other Pacific Isl.	Other		Polly Bradford 23205
	If applicable, please state your Iwi here				I-Pen Hsu 36475
Occupation	Current Occupation			Sophie Hodgins 59505	
				James Parsons 59523	
				Dee Sills 75140	

Transfer of Records	<i>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.</i>		
<i>For children under 12, please present vaccination history to reception</i>	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor and/or Practice Name	Address/Location	

Patient Survey	<i>From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services.</i>		
Participation is voluntary and anonymous	<input type="checkbox"/> Yes, I am happy to participate	<input type="checkbox"/> No, I do not wish to participate	
Survey Contact Details	<input type="checkbox"/> As provided (or)	Alternative Mobile Phone	Alternative Email Address

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. <i>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>	

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)	
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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 Assitanship 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	
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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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Signatory Details	Signature	Day / Month / Year of Signing	Self Signing	Authority
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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)		