PATIENT ENROLMENT FORM

EDI: wdaniels

Remuera Doctors Limited
Address: Airlie Court, 320 Remuera Road, Remuera, Auckland 1050
Postal: P.O. Box 28306, Remuera, Auckland 1541

Phone 09 524 6504
Fax 09 524 7793
Email: reception@remueradoctors.co.nz

ONE ENROLMENT FORM FOR EACH PATIENT PLEASE
PATIENTS AGED 16 YEARS AND OVER MUST COMPLETE AND SIGN THEIR OWN FORM

Please Tick: ☐ **ENROLLING** ☐ **UPDATE / RE-ENROLLING**	**Today's Date:**	**NHI:**
Title Mr Mrs Ms Miss Mast Dr Other – please state:	**Surname:**	**First name(s):**
Preferred Name:	**Other names known by (e.g. maiden name):**	
Gender ☐ Male ☐ Female ☐ Gender Diverse	**Date of Birth** (day/month/year): _________/_________/_________	
Physical address in New Zealand:		**Place of Birth**
Suburb		City/Town
City/Town	Postcode	Country

Postal address in New Zealand:	**Contact details**	
	Day phone	Night phone
	Mobile	Email

Which ethnic group do you belong to? Mark the space or spaces which apply to you			
	American		Japanese
	Australian		Korean
	Brazilian		Māori
	British		Middle Eastern
	Canadian		NZ European
	Chinese		Samoan
	Filipino		South African
	Indian		Tongan
Other – Please state:			

Occupation	Would you like to receive text messages from us regarding lab results, recalls, etc.? ☐ Yes ☐ No
Please nominate an Emergency Contact person in New Zealand: Name: Relationship to you: Phone:	
Private Health Insurer:	
Community Services Card? ☐ Yes ☐ No	Card number Expiry date
High User Health Card? ☐ Yes ☐ No	Card number Expiry date

Do you smoke? ☐ Yes	☐ I used to smoke (Less than 12 months ago) ☐ I used to smoke (More than 12 months ago)	☐ I have never smoked (other than behind the bike shed at school ☺)

Transfer of records: for continuity of care, I agree to the practices transferring my records from previous doctor. I also understand that I will be removed from their practice register. PLEASE NOTE: WE CAN ONLY REQUEST NOTES FROM DOCTORS IN NEW ZEALAND.		
☐Yes ☐No ☐N/A	Doctor's name and/or Medical Practice:	
Address/location	Signature	Date

GP2GP Preferred: ☐ Dr Anton Wiles 8475 ☐ Dr Patrina Hurley 30707 EDI: wdaniels

PLEASE TURN OVER

My declaration of entitlement and eligibility

I am entitled to enrol because I am residing permanently in New Zealand. *The definition of residing permanently in New Zealand is that you intend to be resident in NZ 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 **<u>not</u> a New Zealand citizen,** please tick which eligibility criteria applies to you (b - j) below:

b	I hold a resident visa or 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 that I have been in New Zealand or intend to stay in New Zealand for at least two consecutive years	☐
d	I have a work visa/permit and can show that I am able to be in New Zealand for at least two years (previous permits included)	☐
e	I am an interim visa holder who is 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 New Zealand Aid Programme student studying in New Zealand 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 New Zealand 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
Parent or Caregiver to sign if you are under 16 years

I intend to use **<u>Remuera Doctors Limited</u>** as my regular and ongoing provider of general practice / GP / health care services.

I understand that by enrolling with Remuera Doctors Limited, I will be included in the enrolled population of the Primary Health Organisation (PHO) this practice belongs 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 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: ProCare Health Limited, Level 2, 110 Stanley Street, Grafton, Auckland. Ph 09 377 7827. www.procare.co.nz

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 Remuera Doctors Limited 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 to pay for any current charges for services used. Unpaid debts will be referred to a collection agency. I understand that I am liable for any charges I incur in carrying collection services for any unpaid outstanding debts.

Signature		**Date**
OR signed by authority		
Full name of authority:	**Contact phone number:**	**Relationship:**
Signature of authority		**Date**