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|  | C:\Users\jfleming\Desktop\CC logo for email.jpg**ENROLMENT FORM**  **A:** 17 Antares Place, Rosedale, Auckland, 0632  **P**: 09 477 2090  **Email**: [reception@hzmedical.co.nz](mailto:reception@hzmedical.co.nz)  **EDI : milenumc** |

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| **Provider: GP2GP***:* Dr Simon Mayhew #16430  Dr John Mayhew #10737  Dr Sam Mayhew # 66570  Dr Valentina Kirova Veljanovska #28754  Dr Michaela Wood # 22257 | **NHI** *(Office Use Only)* |

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| **Legal Name \*** |  |  | | | |  | |  | |
| (Title) | Given Name | | | | Middle Name(s) | | Family Name | |
| **Other Name(s)**  (eg. maiden name /preferred name) | |  | | | |  | |  | |
| **Birth Details \*** | |  | | | |  | |  | |
| Day/Month/Year of Birth | | | | Place of Birth | | Country of Birth | |
| **Gender \*** | |  |  |   Gender diverse (please state) | | | | | |
| Male | Female |
| **Optional** | | Marital Status | | | | | | Occupation | |
| **Usual Residential Address \*** | |  | | | | |  | |  |
| House (or RAPID) Number and Street Name | | | | | Suburb/Rural Location | | Town/City and Postcode |
| **Postal Address**  (if different from above) | |  | | | | |  | |  |
| House Number and Street Name or PO Box Number | | | | | Suburb/Rural Delivery | | Town/City and Postcode |
| **\*Contact Details** | |  | | |  | |  | | |
| Mobile Phone | | | Home Phone | | Email Address | | |
| **\*Emergency Contact/NOK** | |  | | | | |  | |  |
| Name | | | | | Relationship | | Mobile (or other) Phone |

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| **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 | |
| **Transfer of Records** | *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, as I am only able to be enrolled at 1 practice at a time in NZ* | | | | | |
|  Yes, please request transfer of my records | | | |  No transfer |  Not applicable |
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| Previous Doctor and/or Practice Name | | | | Address/Location | |

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| **\*Ethnicity Details**  Which ethnic group(s) do you belong to?  ***Tick the space or spaces which apply to you*** | New Zealand European  Maori  Samoan  Cook Island Maori  Tongan  Niuean  Chinese  Indian  Other (such as Dutch, Japanese, Tokelauan). Please state | **Primary Language Spoken** |
| **IWI** |
| \* Smoking status (if over 15) Never smoked 🞎 Ex-smoker 🞎 Greater than 15months🞎 less than 12 months 🞎 Current smoker 🞎  Would you like support to quit? Yes 🞎 No 🞎 |
| I authorise **HealthZone Medical** to contact me via text message  I authorise **HealthZone Medical** to contact me via email  (non-secure) |

HealthZone Medical Enrolment Form October 2017 (NES compatible)

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| **\*** My declaration of entitlement and eligibility  **\*** |

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| **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* |

**I am eligible to enrol** because:

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| 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:

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| 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 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 |  |

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| **I confirm** that, if requested, I can provide proof of my eligibility |  | Evidence sighted (*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 / health care services.

**I understand** that by enrolling with **HealthZone Medical** I will be included in the enrolled population of Comprehensive Care 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 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 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.

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| **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.***

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| **Authority Details**  *(where signatory is not the enrolling person)* |  |  |  |
| Full Name | Relationship | Contact Phone |
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| **Authority Details** | Basis of authority (e.g. parent of a child under 16 years of age) | | |