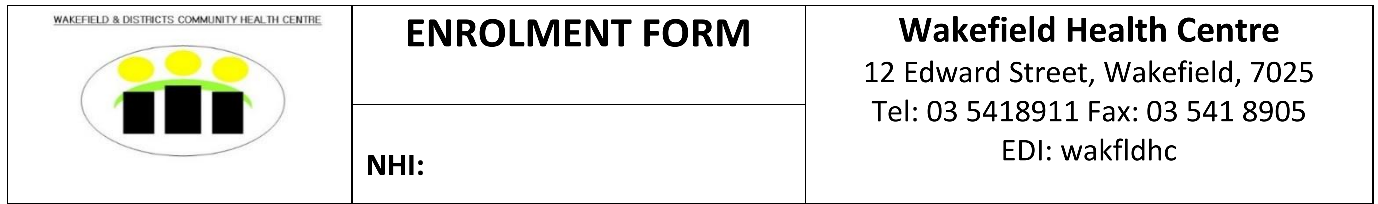

ENROLMENT FORM

NHI:

Wakefield Health Centre
12 Edward Street, Wakefield, 7025
Tel: 03 5418911 Fax: 03 541 8905
EDI: wakfldhc

GP2GP Capable:

Dr Mark Fry: NMMC 33059 **Dr Wayne Hurlow: NZMC 47009**
Dr Pip de Hamel: NZMC 14657 **Dr Eloise Fry: NZMC 36446**
Dr Kim Hurlow: NZMC 40749 **Dr Richard van Gelder Horgan NZMC 66896**

ID Sighted – please state
Passport and/or birth certificate
ID -
ID -

Legal Name	**Title**	**Family Name**	**First Name**	**Middle Name(s)**
Preferred Name		**Preferred Other Family Name**	**Preferred Other Given Name(s)**	
Birth Details		**Day / Month / Year of Birth**	**Place of Birth**	**Country of birth**
Gender	☐ **Male** ☐ **Female** ☐ **Other**		**Reason for "Other" status**	**Can we text you with results?** Delete as appropriate **YES / NO**

Usual Residential Address	**House (or RAPID) 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**

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

Your Contact Details	**Mobile Phone**	**Home Phone**	**Email Address**
Emergency Contact Details	**Name**	**Relationship**	**Mobile (or other) Phone**

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
- ○ Niuen
- ○ Chinese
- ○ Indian
- ○ Other (such as Dutch, Japanese, Tokelauan). Please state

____

EMPLOYER CONTACT DETAILS

Employer Address:

Employer Phone Number:

SMOKING STATUS
Do you smoke tobacco? (Please tick one box)

Current Smoker: ☐	Never smoked: ☐
Past Smoker *(Given up more than 12 months ago)* ☐	Given up in the past 12 months ☐

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.

☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
Previous Doctor and/or Practice Name	Address / Location	

Patient Survey	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. Participation is voluntary and anonymous.		
Patient Survey Contact Details	☐ As provided **(or)**	Alternative Mobile Phone	Alternative Email Address
	☐ No, I do not wish to participate in the Patient Survey		

My declaration of entitlement and eligibility

I intend to use this practice as my regular and on-going provider of general practice / GP / 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 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 meets one criterion in clauses a–f above and 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	☐

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

I have read and agree to Wakefield Medical Centre's Terms of Trade and **understand** that I will be liable for any recovery cost associated with the non-payment of Practice Fees.

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.

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)		