ENROLMENT FORM

Oct 2020

Practice Name- Medical Corner Doctors 237 High Street, Rangiora PH 03 313 7877 Fax 03 313 7861	Doctor Name: EDI: brownrga	NHI (Office use only)

Legal Name	(Title)	Given Name		Middle Name(s)	Family Name	
Other Name		Other Name		Other Given Name(s)	Other Family Name (eg. maiden name)	
Preferred Name		Preferred Name		Date of Birth	Place of Birth	Country of Birth
Gender		Male	Female	*Other	*Reason for "Other" status	Iwi

Usual Residential Address	House (or RAPID) Number and Street Name		Suburb		
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	
Smoking Status	Smoker	If yes, would you like any support to quit? Yes No	Ex-Smoker >12mths <12mths	Never Smoked	
Contact Details	Mobile Phone	Home Phone	Work Phone	Email Address	
Emergency Contact	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 ○ Niuean ○ Chinese ○ Indian ○ Other (such as Dutch, Japanese, Tokelauan). Please state;

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	

Office use only	Evidence of Eligibility sighted YES/NO

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.

TERMS OF BUSINESS

By signing this form you signify that you have read these terms and agree to them all.

I intend to use this practice as my preferred and long term provider of general practice services.

I agree that any relevant information on my treatment may be supplied to government agencies as long as the information is collected for lawful purposes and connected with the statutory functions of these agencies.

I agree that any relevant information on my treatment may be supplied to other doctors, agencies or hospitals when my case has been referred to them for specialist services.

I authorise Medical Corner Doctors to obtain my medical records from my previous General Practitioner.

I authorise my previous medical centre to inform Medical Corner Doctors of any unpaid debt that I may have with them.

Medical Corner Doctors reserves that right to decline or terminate the enrolment if there are concerns re payment for services.

I agree to make payment for all services that are provided to me by Medical Corner Doctors, this payment is required at the time of consultation.

I agree that if the account is not settled this may result in the withdrawal of non-urgent services and your account will be forwarded to a debt collection agency.

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)		

TRANSFER OF RECORDS FROM PREVIOUS MEDICAL CENTRE (if new to the practice only)

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	

Practice Name- Medical Corner Doctors 237 High Street, Rangiora	Doctor Name:	NHI (Office use only)

		Given Name	Middle Name(s)	Family Name

Office Use Only

EDI; brownrga	MC#		
Dr Nigel Tapper	12103	Dr Viv Binney	20379
Dr Begona Goyache	70049	Dr Amanda Torkington	60861
Dr Lorna Archer	15634	Dr Alvin Ling	45152
Dr Stephen Walsh	18244	Dr Gert Gammelin	75032

Photo ID provided and photocopied	YES/NO