Matamata Medical Centre

**ENROLMENT FORM**

**56 Rawhiti Avenue, Matamata**
**Ph (07) 8819102 Fax (07) 881 9103**

National Hauora Coalition

# ENROLMENT FORM

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|---|---|---|---|---|
| **Legal Name*** | (Title) | **Given Name** | **Other Given Name(s)** | **Family** |
| **Other Name(s)** ( eg.maiden name) Please tick the name you prefer to be known as | | **NHI** (office use only) | | **I.D.:** Photo ID sighted ☐ Address Verified ☐ |
| **Birth Details*** | | **Day/Month/Year of Birth*** | **Country of Birth*** | **Place of Birth*** |
| **Gender*** | | ☐ **Male** ☐ **Female** | ☐ **Gender diverse (please state)** | **Occupation** |
| **Employer/Work** | | | **Work Address** | **Work Phone** |
| **Usual Residential Address*** | | **House# and Road/Street name** | **Suburb/Rural Location** | **Town / City & Postcode** |
| **Postal Address** (if different from above) | | **House # & Street Name or PO Box #** | **Suburb/Rural Location** | **Town / City & Postcode** |
| **Contact Details** | **Mobile Phone** | **Home Phone** | **I agree to receiving TXT messages: Yes** ☐ **No** ☐ / **Email Address** | |
| **Emergency Contact/NOK** | | **Name** | **Relationship** | **Mobile (or other) Phone** |
| **Previous Residential Address*** | | | **Suburb/Rural Location** | **Town / City & Postcode** |
| **Iwi:** | | | | |
| **Hapu:** | | | | |

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| **Ethnicity Details** | **Smoking Status** | Smoker ☐ Never Smoked ☐ Ex-Smoker ☐ Years since quit |
| Which ethnic group do you belong to? (Tick which apply to you, if more than 1 please number in order what you go by e.g 1 Maori, 2 Tongan) | Smoking Brief Advice given: Yes/No Appointment with Nurse: Yes/No | |
| | **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.* | |
| ☐ New Zealand European | **Patient Survey Contact Details:** ☐ **YES** **or** ☐ **NO** I do not wish to participate in the Patient Survey | |
| ☐ Maori | **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.** | |
| ☐ Samoan | | |
| ☐ Cook Island Maori | ☐ Yes, please request transfer of my record ☐ No transfer | ☐ Not applicable |
| ☐ Tongan | Previous Doctor and/or Practice Name: | Address / Location |
| ☐ Niuean | | |
| ☐ Chinese | | |
| ☐ Indian | | |
| ☐ Other (such as Dutch, Japanese, Tokelauan). Please state: | **Office use only- Please send via GP2GP** We do not accept EDI, CD disks or USB sticks. | |
| | **EDI: matamedc** **Doctor:** | **NZMC:** |

# My declaration of entitlement and eligibility

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| **I am entitled to enrol** because I am residing permanently in New Zealand.<br>*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 **<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 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 the **Matamata Medical Centre**. I will be included in the enrolled population of the National Hauora Coalition PHO, 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.

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