Patient Enrolment Form

EAST HEALTH TRUST
primary health organisation

Practice Name: Botany Town Centre Medical Practice	Phone number: 09 273 6003
Address: 564 Chapel Road Botany	EDI number: tirakau
P O Box 64060, Botany, Manukau, 2163	Fax number: 09 273 6004

Title Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Full Name _____

NHI:	**Date of birth:**
Gender: ☐ Male ☐ Female	**Country of birth:**

Community Services Card
☐ YES / ☐ NO
Card number:
Card Expiry Date:

High User Health Card
☐ YES / ☐ NO
Card number:
Card Expiry Date:

Residential Address		
Postal address (if different)		

Home Phone	**Work**	**Mobile**
Do you agree to receive emails: ☐ Yes ☐ No		**Next of Kin:**
Email:		**Relationship:** **Tel. contact:**

Do you agree to receive text messages?	**☐ Yes ☐ No**	**Do you Smoke?**	**☐ Yes ☐ No (ex smoker) ☐ Never**

Which ethnic group do you belong to? Mark the space or spaces which apply to you	
11 - New Zealand European	
21 - Maori	
31 - Samoan	
32 - Cook Islands Maori	
33 - Tongan	
34 - Niuean	
42 - Chinese	
43 - Indian	
Other such as Dutch, Japanese, Tokelauan (please state)	

Transfer of records

In order to get the best care possible, I agree to this Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register.

☐ Yes ☐ No ☐ Not applicable

Doctor's name:
Address:

Phone:

Signature _____
(agreement for transfer of records)

GP2GP for Pieter Vosloo NZMC # 20138:

Please turn over

Enrolment in the Practice/Primary Health Organisation (PHO)

I intend to use **Botany Town Centre Medical Practice** as my regular and ongoing provider of general practice/GP/first level primary health care services:

I am entitled to enrol because **I am residing permanently in New Zealand** (intend to be resident in NZ for at least 183 days in the next 12 months) and meet **one** of the following criteria:

a) I am a New Zealand citizen	**OR**	Yes / No
b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	**OR**	Yes / No
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	**OR**	Yes / No
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)	**OR**	Yes / No
e) I am an interim visa holder who was eligible immediately before my interim visa started	**OR**	Yes / No
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	**OR**	Yes / No
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**	Yes / No
h) I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder	**OR**	Yes / No
i) 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)	**OR**	Yes / No
j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	**OR**	Yes / No
k) I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship fund		Yes / No

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 choose to enrol with this practice as my regular and ongoing provider of general practice/GP/first level primary health care services.
✓ I understand that by enrolling with this practice I will be enrolled with the Primary Health Organisation (PHO) this practice belongs to, and my name, address and other identification details will be included on both the Practice and the PHO enrolment register.
✓ 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 with the PHO, and their contact details.
✓ I have read and I agree with the Health Information Privacy Statement in accompanying PHO information pamphlet.
✓ I agree to inform the practice of any changes in my eligibility.

	/ / day month year
Signature of patient enrolling	**Date**

Or signed by authority *

Full name of authority	Contact Phone number	Relationship
Address	Signature of Authority	/ / day month year
Detail the basis of authority (e.g. parent of a child under 16 years):		

* An authority is the legal right sign for another person if for some reason they are unable to consent on their own behalf.

Please turn over