ENROLMENT FORM

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|  | **14 Queen Street, PO Box 242, Te Puke****Phone 07 573 9511 Fax 07 573 4815****EDI – tepukemc** [**www.tepukemedicalcentre.co.nz**](http://www.tepukemedicalcentre.co.nz)**Email: Tepuke.Admin@raphs.org.nz** |
| **Preferred GP** | **\*Photo I.D. e.g. Passport, Driver’s License** | **\*NHI** |

**\*Fields above for Office Use ONLY**

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| --- | --- | --- | --- |
| **Legal Name** | Mr Mrs Ms Miss Dr Mx | Surname/Family Name | First/Given Name |
| Middle Name(s) | Preferred Name | Maiden Name |
| **Birth Details** |  |  |  |
| Day / Month / Year of Birth | Place of Birth | Country of Birth |
| **Gender** |  Male  Female Gender diverse (please state) | Primary Language |

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| **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 |

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| **Next Of Kin / Emergency Contact** | Name | Relationship | Mobile (or other) Phone |
| Address |

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| **Community Services Card** |  |  |  |  |
| Yes | No | Day / Month / Year of Expiry | Card Number (if known) |
| **High User Health Card** |  |  |  |  |
| Yes | No | Day / Month / Year of Expiry | Card Number (if known) |

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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:****………………………………****IWI ………………………………** | **Occupation** |  |
| **Employer & Address** |  |
| **Smoking Status ( applies to 15 years & over ONLY)**Never smoked 🞎 Current smoker 🞎 Current vaper 🞎 Ex-smoker 🞎 Approximate Quit Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Would you like support to quit? Yes 🞎 No 🞎 |
| **For Women**When was your last cervical smear?...........Have you ever had an abnormal smear? **Yes/No** If yes – ‘when’?Have you had a mammogram**? Yes/No** If yes – ‘when’?**Woman aged 45-69 years:** Are you enrolled with Breast Screening Aotearoa Midlands? **Yes/No***If you are enrolled with Breast Screening elsewhere (outside Midland area) you will need to enrol here.*If No, do you agree to enrol with Breast Screening Aotearoa Midlands? **Yes/No** *If you prefer to have Breast Screening done privately, you are still entitled to be enrolled with* *Breast Screening Aotearoa Midland.* |

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| **Consent to Receive Communications: *Please tick applicable boxes to give your consent:*** |
|  Text Message  | Patient Portal (secure) |  Email (non-secure) |

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| **Who is your preferred pharmacy so we can email your prescription if required?****Pharmacy Name & Address…………………………………………………………………………………………….……………………………………………………****Do you have any severe allergies? Yes/No** *(If Yes, please state the allergies you have)***…………………………………………………………………………………………………………………………….………………………………………………………………****ENROLMENT FORM** |
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| **\*My declaration of entitlement and eligibility\*** |
| **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 |  |
| **I confirm** that I have provided proof of my eligibility |  | Evidence sighted (*Office use only*) |

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| **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 **Te Puke Medical Centre** I will be included in the enrolled population of **Western Bay of Plenty** **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 or informed** 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 the** Health Information Privacy Statement and acknowledge that the information I have provided on the Enrolment Form will be used to determine eligibility to receive publicly-funded services. I also acknowledge that my information may be shared with other agencies, but only when permitted under the Privacy Act and Health Information Privacy Code.

**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.

**I agree to the Terms of Trade of Te Puke Medical Centre and undertake to** pay any fees applicable for Practice Services & all costs incurred in collection of any debt for me & my dependents.

**I agree to the full Terms and Conditions of Te Puke Medical Centre** (https://www.tepukemedicalcentre.co.nz/enrolment-fees/)

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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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| Basis of authority (e.g. parent of a child under 16 years of age) |

Western Bay of Plenty PHO - Primary Health Services Provider Enrolment Form NES Compliant August 2022

Request Form to Transfer Medical Records to Te Puke Medical Centre



# 14 Queen Street

# (P O Box 242)

**TE PUKE 3153**

[**www.tepukemedicalcentre.co.nz**](http://www.tepukemedicalcentre.co.nz)

**Tepuke.Admin@raphs.org.nz**

**Ph: 07 5739 511Fax: 07 5734 815 EDI: tepukemc**

**Transfer of Records Authority**

*In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor.*

*I understand I will be removed from their practice register, as I am only able to be enrolled at 1 practice at a time in NZ.*

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
|  Yes - please request transfer of my records (see below)  Not Applicable  No |

**I hereby authorise you to release my/our medical records.**

**Please Note: If patient is under 16 years old this form must be signed by an authorised agent.**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sign\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Patient/Parent/Guardian (circle)**

**Your Previous Medical Centre’s Name and Address:**

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**Dear Doctor**

**The patient above has now joined our medical practice. Please forward all of their medical records including old paper medical records.**

**One of the following doctors has been allocated to this patient:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Dr Alexander Leslie** | **NZMC 59525** | **Dr Stewart Montgomery** | **NZMC 28924** |
| **Dr Scott Rieper** | **NZMC 73592** | **Dr Brynn Ong** | **NZMC 71884** |
| **Dr Julea Dalley** | **NZMC 49870** | **Dr Lisa Wain** | **NZMC 69478** |
| **Dr Michelle Stewart** | **NZMC 73618** | **Dr Elaine Pooler** | **NZMC 19361** |