ENROLMENT FORM

ELLERSLIE MEDICAL CENTRE

41 Robert Street,
Ellerslie,
Auckland 1051
EDI: ellsmedc
Phone: 09 579 6147
www.ellersliemedical.co.nz

edi: ellsmedc
Dr Andrea Steinberg NZMC 19234 (Please use GP2GP)

NHI *(Office use only)*

Name	(Title)	Given Name	Other Given Name(s)	Family Name
Other Name(s) (e.g. maiden name) Please **tick** the name you prefer to be known as				
Birth Details		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender	☐ Male ☐ Female ☐ Gender diverse (please state)			Occupation
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	Work Phone	
Emergency Contact		Name	Relationship	Mobile (or other) Phone
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	

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

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	
Patient Portal Would you like to be signed up to the portal?	☐ Yes, email: *Please provide a unique email per adult and children over 16.*	☐ No
Newsletter Would you like to be signed up to our newsletter? This is only used for urgent and important notifications.	☐ Yes, email if different:	☐ No

ELLERSLIE MEDICAL CENTRE	**DECLARATION OF ENTITLEMENT AND ELIGIBILITY**	41 Robert Street, Ellerslie, Auckland 1051 EDI: ellsmedc Phone: 09 579 6147 www.ellersliemedical.co.nz

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 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	☐

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 this practice, I will be included in the enrolled population with the Primary Health Organisation (PHO) this practice belongs 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 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.

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)		

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MEDICAL HISTORY

Full Name_____

Personal History

Current Medical Problems

Current Medication

Allergies (for medicines)

Smoking History ☐ Never Smoked ☐ Current Smoker ☐ Ex-Smoker

Alcohol (how many units per week)

Other Drug Use

Weight: Height:

Past History

☐ Asthma	☐ Epilepsy	☐ Stroke	☐ Other (please list)
☐ Diabetes	☐ Kidney Disease	☐ Heart Attack	
☐ High Blood Pressure	☐ High Cholesterol	☐ Operations:	
☐ Hepatitis	☐ Any Cancers:		
☐ COPD			

Family History

Do any of the above or other conditions run in your family? Please list below

Screening and Immunisation

Childhood Immunisations	☐ Up to date	☐ Only some or none
Cervical Smears (women aged 20-70)	☐ Yes, last done: ☐ Previous abnormal smear	☐ Never had one
Mammograms (women aged 45-69)	☐ Yes, last done:	☐ Never had one

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DEBT POLICY

For your convenience, our bank account details are on bottom of each invoice, on our website ellersliemedical.co.nz, and on Healthpoint. The reference number is your chart number noted on your invoice.

We are committed to providing you the best possible care. However, in order to do this and maintain our fees at a reasonable level, please be aware of our policy with regard to payment of your account:

- Payment for Consultation and/or service is expected on the same day of the service. This may done at reception or once a credit history has been established, may be done through online banking within 24 hours at ASB 12-3060-0245732 Ellerslie Medical Centre.
- Payments not made on the same day will incur an account fee of $5.00 for each calendar month of nonpayment. This fee will be reversed if payment is received within 14 days of the service.
- Credit exceeding $100 Dollars is not permitted. Service may be refused if account remains unpaid unless there is a clinically urgent need.
- All unpaid accounts 60 days overdue will be handed over to the debt collection agency and the costs associated with this will be added to the patient's account for payment.
- Ellerslie Medical Centre reserves the right to vary this policy as it sees fit.

Should you have any queries regarding this policy, please feel free to contact us.

We would appreciate your signature at the bottom of this form to acknowledge that you have read, understand and agree to this policy.

Administration Team

Ellerslie Medical Centre

I acknowledge that I have read the above policy and agree to abide by these terms of payment.

Printed Name of Patient/ Account Holder: _____

Signature of patient/ Account Holder: _____

Signed Date: ___/___/_____