

 ELLERSLIE MEDICAL CENTRE	<h1>ENROLMENT FORM</h1>	41 Robert Street, Ellerslie, Auckland 1051 Phone: 09 579 6147 Fax: 09 525 6887 www.ellersliemedical.co.nz
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EDI: ellsmc Dr Andrea Steinberg NZMC 19234 (Please use GP2GP)	NHI (Office use only)
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Name	(Title)	Given Name	Other Given Name(s)	Family Name
Other Name(s) (e.g. maiden name)			Email address (16yrs old and above must use their own email address)	
Birth Details	Day / Month / Year of Birth		Place of Birth	Country of birth
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)	Occupation
Usual Residential Address	House 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.			
	<input type="checkbox"/> Yes, please request transfer of my records		<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor and/or Practice Name		Address / Location	
Ethnicity Details Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	<input type="radio"/> New Zealand European	Community Services Card		
	<input type="radio"/> Other European	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="radio"/> Maori	Day / Month / Year of Expiry	Card Number	
	<input type="radio"/> Samoan	Patient Portal Would you like to sign up to the portal? (for appointment bookings & blood test results online)		<input type="checkbox"/> Yes <input type="checkbox"/> No Children age 15 or under can be under <u>one</u> of their parent's portal account. If above email belongs to family, please state relationship to patient:
	<input type="radio"/> Cook Island Maori	Newsletter If you provided us with an email address above, we will automatically sign you up to receive our newsletter. This is only used for urgent and important notifications. Please tick No if you do not wish to receive newsletters.		
<input type="radio"/> Tongan				<input type="checkbox"/> No
<input type="radio"/> Niuean				
<input type="radio"/> Chinese				
<input type="radio"/> Indian				
<input type="radio"/> Other (e.g. Dutch, Japanese, Tokelauan). Please state:				
	SMS Text Messaging			<input type="checkbox"/> No
	If you do not wish to be texted by the practice please tick no			



DECLARATION OF ENTITLEMENT AND ELIGIBILITY

41 Robert Street, Ellerslie,
Auckland 1051
EDI: ellsmc
Phone: 09 579 6147
Fax: 09 525 6887
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

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I am eligible to enrol because:

a	I am a New Zealand citizen <i>(If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below)</i>	<input type="checkbox"/>
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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)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>

I confirm that, if requested, I can provide proof of my eligibility

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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	<input type="checkbox"/> Self-Signing	<input type="checkbox"/> Authority
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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 <i>(where signatory is not the enrolling person)</i>	Full Name	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age)		

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

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Heart Attack | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Operations: | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Any Cancers: | | |
| <input type="checkbox"/> COPD | | | |

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

_____**Screening and Immunisation**

- | | | |
|------------------------------------|--|--|
| Childhood Immunisations | <input type="checkbox"/> Up to date | <input type="checkbox"/> Only some or none |
| Cervical Smears (women aged 20-70) | <input type="checkbox"/> Yes, last done:
<input type="checkbox"/> Previous abnormal smear | <input type="checkbox"/> Never had one |
| Mammograms (women aged 45-69) | <input type="checkbox"/> Yes, last done: | <input type="checkbox"/> Never had one |

For your convenience, our bank account details are at the 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 be 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 the cost of two doctor consultation fees 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: ____/____/____