

# Waimate Medical Centre - Patient Enrolment Form

84 Queen Street, Waimate 7960

Ph: (03) 689 8016

Fax: (03) 689 8014

EDI: **waimatbs**

**Dr Sarah Creegan - 14465**

## Patient Information

Family Name: \_\_\_\_\_ Given Names: \_\_\_\_\_

Title: Mr/ Mrs/ Miss/ Ms/ Dr      Date of Birth: \_\_\_\_\_      Gender: Male  Female

Home Address: \_\_\_\_\_

Postal Address (if different from above): \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

NHI Number: \_\_\_\_\_

**Text Messaging:** Do you consent to us contacting you by text messaging? Yes  No

This may include appointment reminders and some test results.

**Manage My Health:** Do you consent to using MMH Patient Portal? Yes  No

<b>Ethnicity</b>	Tongan	Chinese
NZ European/Pakeha	Niuean	Indian
Other European	Tokelauan	Other Asian
New Zealand Maori	Fijian	Middle Eastern
Samoaan	Other Pacific Island	Latin American/Hispanic
Cook Island Maori	South East Asian	African
Other (Please Specify)		

## Next of Kin

Family Name: \_\_\_\_\_ Given Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**New Zealand Citizenship:** Are you a New Zealand Citizen Yes  No

**Residency Status:** Are you living in New Zealand on a permanent or long term basis i.e. more than 2 years? Yes  No

**Country of Birth:** Which country were you born in? \_\_\_\_\_

**Do you have a Community Services Card (CSC) or High User Health Card (HUHC)?** Yes  No

CSC Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

HUHC Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

## Smoking Status

Currently a smoker  Ex-smoker  Never smoked

## Transfer of Records from Previous Medical Centre

Name of Previous Medical Centre \_\_\_\_\_

Name of your GP at your previous medical centre: \_\_\_\_\_

I agree to my medical records being transferred from my previous medical centre to this medical centre. Yes  No

### **Eligibility for Funded General Practice Services**

I intend to use the Waimate Medical Centre as my regular and on-going provider of general practice services.

1. I am eligible to enrol because I live in New Zealand and meet one of the following criteria (please tick where appropriate):

- I am a New Zealand citizen; OR
- New Zealand Resident
  - a) Hold a resident visa or a permanent resident visa and intend to stay in New Zealand for a minimum of 2 years; OR
  - b) Australian citizen or permanent resident and able to show intent to stay in New Zealand for at least 2 years; OR
  - c) Work visa/permit holder and can show that I am able to be in New Zealand for at least 2 years; OR
- 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
- Under 18 years and in the care and control of a parent/legal guardian/adopting parent who is a New Zealand Citizen or New Zealand Resident; OR
- Other (Please provide details of entitlement including relevant permit and dates)

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

### **Terms of Business**

By signing this form you signify that you have read these terms, and agree to all of them.

- 1. I intend to use this practice as my preferred and long term provider of general practice services.
- 2. I agree that any relevant information on my treatment may be supplied to government agencies as long as the information is collected for lawful purposes connected with the statutory functions of these agencies.
- 3. I agree that any relevant information on my treatment may be supplied to other doctors, agencies or hospitals when my case has been referred to them for specialist services, and that my GP will receive a report back after such a referral.
- 4. I authorise the Waimate Medical Centre to obtain my medical records from my previous General Practitioner.
- 5. I authorise my previous medical centre to inform the Waimate Medical Centre of any unpaid debt that I may have with them.
- 6. I acknowledge that the Waimate Medical Centre may choose to decline my enrolment in the event that I have a debt with my previous medical centre.
- 7. I agree that payment is required at the time of my consultation.
- 8. I agree to make payment for all services that are provided to me by Waimate Medical Centre.
- 9. I agree that unpaid accounts may be passed on to a debt collection agency, and that any fees incurred in the collection of overdue accounts are payable by me (the debtor).

**By completing and signing this form, I agree that I have read, and understood, the conditions of enrolment above. I further agree that payment will be made at the time of my consultation, and that should payment not be made then the account may be sent to a debt collector, and that collection fees will apply.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

<b>Medical Centre Use Only</b>		<b>Medical Centre Use Only</b>	
Photo ID provided, and photocopied?      Yes <input type="radio"/>		No <input type="radio"/>	
<b><i>(Photo ID must be either NZ Drivers Licence or a Passport)</i></b>			
<b>2 other forms of ID are required. Record details of these below.</b>			
Details of "other" form of ID # 1		Details of "other" form of ID # 2	