Waimate Medical Centre - Patient Enrolment Form

84 Queen Street, Waimate 7960

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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:** _____ **Work Phone Number:** _____

NHI Number: _____

Text Messaging: Yes ◯ No ◯
Do you consent to us contacting you by text messaging?
This may include appointment reminders and some test results.

Email Messaging: Yes ◯ No ◯
Do you consent to us contacting you by email?
This may include appointment reminders and some test results.

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

Ethnicity		Tongan		Chinese	
NZ European/Pakeha		Niuean		Indian	
Other European		Tokelauan		Other Asian	
New Zealand Maori		Fijian		Middle Eastern	
Samoan		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:** _____

Country and Place of Birth: Where were you born ? _____

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 ◯

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).
10. I agree that upon my enrolment I may be required to have a consultation with a practitioner, either at the Medical Centre or over the telephone, to update my medical history etc. The consult may incur the usual fees.

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.

Patient Survey

From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.

◯ ***I do not wish to participate in the Patient Survey***

Signature:_____ **Date:**_____

Medical Centre Use Only	**Medical Centre Use Only**
Photo ID provided, and photocopied? Yes ◯	No ◯
(Photo ID must be either NZ Drivers Licence or a Passport)	
2 other forms of ID are required. Record details of these below.	
Details of "other" form of ID # 1	Details of "other" form of ID # 2