ENROLMENT FORM

The Doctors Middlemore

215 Massey Road, Mangere, Auckland 2024
Phone: 09 275 9977 Fax:09 275 3353 Email:info@md.thedoctors.co.nz
EDI: mangere

Fields marked with an * are compulsory	*Anyone over age of 16 must complete their own enrolment form*	*NHI *(Office use only)*

Dr Amanda Bishop 22074	Dr Allan Tee 22972	Dr Huta Tangaroa 10884	Dr Mark Young 47048	Dr Mahzer Iqbal 61582	Dr Murray Winiata 47043	Dr Tom Bye 49261	Dr Vincent Yiu 33115	Dr Anna-marie O'Mahony 65219

***Name**	Title	First Name(s)	Family Name	Other Names Known By (eg. Maiden name, etc).
***Birth details**	Date of Birth ___/___/_____ Day Month Year	Place & Country of Birth	***Gender**	☐ Male ☐ Female ☐ Gender Diverse (please state)

***Usual Residential Address**	Street Number	Street Name	Suburb	City/Town	Postcode
Postal Address *(if different from above)*	Street Number	Street Name	Suburb	City/Town	Postcode

***Contact details**	Mobile Number	Home Phone	Email Address (☐ tick box to enrol with Manage My Health)	
***Emergency Contact**	Full name of person to contact	Address	Phone number	Relationship
***Employer Details**	Occupation	Employer Name	Employer Address	Employer Phone Number

Transfer of Records	I agree to The Doctors Middlemore obtaining my records from my previous doctor, which will mean I will be removed from their practice register.	
	☐ Yes, please request transfer of my records	☐ Not Applicable
	Previous Practice Name	Previous Practice Address and Ph/Fax number

Ethnicity Details** Which ethnic group(s) do you belong to? ***Tick the space or spaces which apply to you	☐ New Zealand European ☐ Māori Iwi: ☐ Samoan ☐ Cook Islands Maori ☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian ☐ Other such as DUTCH, JAPANESE, TOKELAUAN, FIJIAN Please state:	**High User Health Card**	☐ Yes	☐ No
		Card Number	Card Expiry Date	
		Community Services Card	☐ Yes	☐ No
		Card Number	Card Expiry Date	

Enrolment in the Practice / Primary Health Organisation (PHO)

I am eligible to enrol because I live in New Zealand[9] and meet one of the following criteria

a	I am a New Zealand citizen
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[10] 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
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.

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 ongoing provider of general practice / GP / First Level primary health care services.

I understand that by enrolling with this practice I will be enrolled with the **Primary Health Organisation (PHO)** this practice belongs to, and my name address and other identification details will be included on both the Practice, PHO and National Enrolment Service Registers.

I have been given information about the benefits and implications of enrolment and the services this practice and the PHO provides, and their contact details.

I understand that my **first booked appointment** is **free**.

I understand that if I **visit another provider** where I am not enrolled, I may be **charged a higher fee**.

I understand that that I am **expected to pay** for my **medical service on the day of my visit** and that a **surcharge will be added** if I am unable to do so.

I understand that if **I transfer to another medical health provider within three months**, I will then be **charged** for my first visit at the clinic's **casual rate** and invoiced accordingly.

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 eligibility.

*SIGNATURE	*DATE
	/ / Day Month Year

OR Signed by AUTHORITY[11] an authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Full Name of Authority	Contact Phone Number	Relationship
Address	Signature of Authority	/ / Day Month Year
Detail the basis of authority (e.g. parent of a child under 16):		

Office Use Only	NES	Trans in.	Alerts	MMH	NOK	Scanned	Checked by: