ENROLMENT FORM

652 GREAT SOUTH ROAD, MANUKAU AUCKLAND 2104
PHONE: 09 262 0072 FAX: 09 262 0079 EDI: southpfd

TITLE:	FIRST NAME(S):*	FAMILY NAME:*	NHI: (Office Only)

OTHER NAMES KNOWN BY (E.G. MAIDEN NAME)	PREFERRED NAME:	GENDER:*
		MALE FEMALE GENDER DIVERSE: PLEASE STATE

DATE OF BIRTH:*	COUNTRY & PLACE OF BIRTH:*	OCCUPATION & EMPLOYER
DAY MONTH YEAR _____/_____/_____		

RESIDENTIAL ADDRESS*	STREET NUMBER	NAME OF STREET	SUBURB	CITY/TOWN	POST CODE

POSTAL ADDRESS		HOME PHONE:	
		WORK PHONE:	
MOBILE	TICK BOX FOR NO TXTS ☐	COMMUNITY SERVICE CARD	CARD NUMBER EXPIRY DATE
EMAIL	TICK BOX FOR NO EMAILS ☐	HIGH USER HEALTH CARD	CARD NUMBER EXPIRY DATE

EMERGENCY* CONTACT (NEXT OF KIN)	FULL NAME:	RELATIONSHIP:	PHONE NUMBER:	OTHER DETAILS:

ETHNIC GROUP – * Tick the space or spaces which apply to you.

☐ NEW ZEALAND EUROPEAN	☐ MAORI - IWI:	
☐ SAMOAN	☐ COOK ISLAND MAORI	☐ TONGAN
☐ NIUEAN	☐ TOKELAUAN	☐ FIJIAN
☐ CHINESE	☐ INDIAN	
☐ OTHER (SUCH AS FILIPINO, VIETNAMESE, JAPANESE, AUSTRALIAN, AMERICAN, DUTCH, ITALIAN ETC.) PLEASE STATE:		

DEPENDANTS - listed on this form will also be enrolled in the PHO as long as I am legally entitled to sign on their behalf

NHI	FIRST NAME(S)	FAMILY NAME	GENDER	ETHNICITY	PLACE OF BIRTH	DATE OF BIRTH

SMOKING STATUS	☐ CURRENT ☐ NEVER SMOKED ☐ EX-SMOKER

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

I understand that the Practice participates in a national survey about people's health care experience and how their overall 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. TICK HERE TO OPT OUT/DECLINE ☐

Have you heard about our Manage My Health App? You can book appointments, request for repeat prescriptions, view your results and more! All from the comfort of your smartphone or computer. If you have any questions please ask our friendly reception staff. Sign up today!

My declaration of entitlement and eligibility

TICK THE BOXES THAT APPLY TO YOU

I AM ENTITLED TO ENROL because I am residing permanently in New Zealand. **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 I can provide proof of my eligibility	☐	Evidence sighted and scanned (*Office use only*)

EXAMPLES: NZ PASSPORT *OR* PASSPORT & CURRENT VISA *OR* NZ BIRTH CERTIFICATE PLUS PHOTO ID. IF YOU HAVE NEITHER PLEASE TALK TO RECEPTION.

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 **Southpoint Family Doctors** I will be included in the enrolled population of **PHO: Alliance Health Plus,** 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 agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

I acknowledge that all fees must paid in full on the day, unless prior arrangement is made with Management. An administration fee will be added to all outstanding accounts at the end of the each month. A further fee will be incurred if the overdue amount is sent to the Debt Collector including their collection fee.	☐ Tick Here

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
Authority Details	Basis of authority (e.g. parent of a child under 16 years of age)		

How did you come to find Southpoint Family Doctors?

☐ Website	☐ Google	☐ Facebook	☐ Walking by	☐ Pharmacy
☐ Dentists	☐ Physiotherapist	☐ Friend/Family/Colleague: (name)		