mercurybay medicalcentre
providing remote RURAL primary care

Pinnacle Midlands Health Network

PATIENT ENROLMENT FORM

Each person 16 years or over to complete and sign own form

PLEASE USE BLACK PEN TO FILL FORMS

I wish to enrol with: Dr Gwyn Van Der Byl Dr Amanda Dornfeld

Fields with * Must be completed

NHI: (Office Use Only)*

1. Personal Details: Your legal name is required

Title: **Family Name:*** **First Name/s:***

Preferred Name: **Other name/s known by and/or Maiden name:**

Date of Birth:* **Sex at birth:*** Please Tick ✓ M F

Gender you would like to be identified as If diverse please state M F **Gender Diverse**

2. Contact Details:

Physical Address:*

Unit/House Rapid No: **Street:** **Suburb or Rural area:**

Town or City: **Postcode:**

WORK Phone: 0

HOME Phone: 0

MOBILE Phone: 0

Postal Address: (If different from Physical Address)

PO Box/Unit/ House No: **Street:** **Suburb/Rural Delivery:**

Town/City: **Postcode:**

Email:

3. Contact Methods:

The team prefer to make contact through our secure email portal:

Please talk to the team regarding **Manage My Health**

Also please note: When a staff member calls, screens will display private number.

Consent to use text messaging **YES** **NO** *Please circle one*

4. Birth Place and Ethnicity Details:

Ethnicity Details: Which ethnic group(s) do you belong to? *Tick the space or spaces which apply to you*	☐ New Zealand European ☐ Maori ☐ Samoan ☐ Cook Island Maori ☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian ☐Other (Such as Dutch, Japanese, Tokelauan.) please state ……..	BORN IN New Zealand *Passport/Birth Certificate as proof*	BORN ELSEWHERE *Proof of eligibility required*
		Place of Birth:	Country Of Birth: Visa Expiry *if appropriate*:

5. Next of Kin/Emergency Contact Details:

Title: **Full Name :**

Physical Address:

No: **Street:** **Suburb:**

Town/City: **Postcode:**

DAY Phone: 0

HOME Phone: 0

MOBILE Phone: 0

Relationship:

6. Community Health Details:

Community Services Card No: **Expiry Date:** / / Sighted: (Office Use Only) Yes No

High User Health Card No: **Expiry Date:** / / Sighted: (Office Use Only) Yes No

7. Employer:

Name:

Address:

Town/City: **Phone:**

Occupation:

MY DECLARATION OF ENTITLEMENT AND ELIGIBILITY*:

	Please Tick
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*	☐

I am eligible to enrol because:

a) I am a New Zealand citizen *(if yes, tick box and go to last box in this section)*	☐

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 current 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 if requested, I can provide proof of my eligibility	☐	Evidence Sighted(*official 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 Mercury Bay Medical Centre I will be included in the enrolled population of the Midlands Regional Health Network Charitable Trust, 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 this 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.

I have read and I agree to your 'Terms and Conditions of Trade'(*Found on the wall beside our price board*)

SIGNATURE*	**DATE*** / / Day Month Year	☐ Self signing	☐ Authority *See below*

AUTHORITY DETAILS

Full Name of Authority:	Contact Phone Number:	Relationship:
Detail the basis of authority (e.g. parent of a child under 16):		

An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf

Loaded & Scanned with supporting documents ☐ **Enrolled & synced in NES** ☐ **By: _____ Date: / /**