MILTON MEDICAL CENTRE LP
7 Eden Street, Milton 9220
P O Box 37, Milton, 9241
Ph: 03 417 8226 Fax: 03 417 4857
GP2GP: Dr Jane Gardner NZMC: 13673
EDI: miltonhc

ENROLMENT FORM		NHI: ***[PAT_NHI_NO]*** Chart No: **[PAT_CHARTNO]**
Title ***[PAT_TITLE]*** Mr Mrs Ms Miss Dr	First Name(s) ***[PAT_GIVENNAME]*** [PAT_MIDNAME]	Family Name ***[PAT_SURNAME]***
Preferred Name ***[PAT_PREFER_NAME]***		Other Names Known By (e.g. maiden name) ***[PAT_PREV_SURNAME]***
Gender □ Male □ Female		Place / Country of Birth [PAT_CTRY_BIRTH]
Physical Address Note that we need Rapid Numbers & Road Address. R D not sufficient.	Street or Rapid of Street (rural) number***[PAT_HOME_STREET]***	Date of Birth ***[PAT_DOB]***
		Occupation ***[PAT_OCCUPATION]***
	[PAT_HOME_SUBURB] Suburb	Community Services Card **YES / NO**
	[PAT_HOME_CITY] [PAT_HOME_POSTCODE] City/Town Postcode	Card Number ***[PAT_CSC_CARDNO]***
		Expiry Date ***[PAT_CSC_EXPDATE]***
Postal Address (If different from above)	***[PAT_POST_STREET] [PAT_POST_SUBURB] [PAT_POST_CITY] [PAT_POST_POSTCODE]***	High User Health Card **YES / NO**
		Card Number ***[PAT_HUHC_NUM]***
		Expiry Date ***[PAT_HUHC_EXPDATE]***
Contact Details Home Phone [PAT_AH_PHONE]	Work Phone[PAT_DAY_PHONE]	Cell [PAT_MOB_PHONE] Email [PAT_EMAIL_ADDR]
Emergency Contact Person ***[PAT_NOK_NAME]***	Relationship ***[PAT_NOK_RELATION]***	Phone No: ***[PAT_NOK_PHONE]*** Cell phone

Which ethnic group do you belong to? Mark the space or spaces which apply to you		**Please Circle Your Smoking Status:** Never smoked Trying to give up Smoker Ex-Smoker **Would you like assistance to help you quit smoking Yes / No**
New Zealand European		**Is there any other information that you would like us to know?**
Māori		
Samoan		
Cook Islands Māori		
Tongan		**Transfer of Records:** In order to get the best care possible, I agree to the release, transfer and disclosure of my records from my previous Doctor. I also understand that I will be removed from their practice register. YES ☐ NO ☐ Not applicable ☐ **Doctor's Name:** **Address / Location:** _____ **National Screening Programmes:** I understand that this practice participates in National Screening Programmes and that I may be enrolled in any relevant Programmes e.g. Cervical or Breast Screening, unless I chose not to: ☐ Accept ☐ Decline
Niuean		
Chinese		
Indian		
Other such as:		
DUTCH		
JAPANESE		
TOKELAUAN		

Enrolment in the Practice / Primary Health Organisation (PHO)

I intend to use **Milton Medical Centre** as my regular and on-going provider of general practice / GP / First Level primary health care services.

I am eligible to enrol because **I live in New Zealand** and meet one of the following criteria:

a) I am a New Zealand citizen **OR**
b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) **OR**
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 **OR**
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) **OR**
e) I am an interim visa holder who was eligible immediately before my interim visa started **OR**
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 **OR**
g) I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one of the criterion in clauses a-f above **OR**
h) I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder **OR**
i) 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) **OR**
j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme **OR**
k) 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.

My agreement to the enrolment process

NB Parent or caregiver to sign if you are under 16 year

I choose to enrol with this practice as my regular and on-going 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 and the PHO Enrolment Register.

I understand that if I visit another 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 with the PHO, and their contact details.

I have read and I agree with the Health Information Privacy Statement.

I agree to inform the practice of any changes in my eligibility.

I understand that payment is expected at time of consultation and any accounts that become outstanding may be referred to a debt collection agency and I may incur extra costs. Please refer to our "TERMS of TRADE" for further details. A full copy is available on request and is displayed on our notice boards.

	/ / Day Month Year
SIGNATURE	**DATE**

OR Signed by AUTHORITY[1]

Full Name of Authority	Contact Phone Number	Relationship
Address	Signature of Authority	/ / Day Month Year

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