Wanaka Medical Centre

23 Cardrona Valley Road, Wanaka

Phone: (03) 443 0710, **Fax:** (03) 443 0711, **Email:** office@wanakamedical.co.nz, **EDI:** wanaka

Patient Enrolment Form

Title - Dr / Mr / Mrs / Ms:

Family Name:

First Name(s):

Preferred Name:

Country of Birth:

Date of Birth: NHI:

Male/Female:

Other Names Known By:
(ie: maiden name):

PHYSICAL ADDRESS:
Street (not PO Box):

Suburb:

Town/City:

Postcode:

POSTAL ADDRESS: (if different)

Home Phone:

Mobile Phone:

Email:

Occupation:

Employer:

Work Phone:

EMERGENCY CONTACT/NEXT OF KIN DETAILS:
Name:
Contact Phone:
Relationship:

FUNDING DETAILS:
Community Services Card? ☐ **Yes** ☐ **No**
High User Card? ☐ **Yes** ☐ **No**
Card Number:
Expiry Date:

Which ethnic group to do you belong to (please tick):

- ☐ **New Zealand European**
- ☐ **Maori - NZ**
- ☐ **Samoan**
- ☐ **Cook Islands Maori**
- ☐ **Tongan**
- ☐ **Niuean**
- ☐ **Chinese**
- ☐ **Indian**
- ☐ **Other European**
- ☐ **Other (such as Dutch, Japanese) Please state:**

Hapu & Iwi (if relevant):

I agree to being contacted by text: ☐ **Yes** ☐ **No**
I agree to being contacted by email: ☐ **Yes** ☐ **No**

SMOKING STATUS:(tick one):

- ☐ **Smoker**
- ☐ **Never Smoked**
- ☐ **Trying to Give Up**
- ☐ **Ex Smoker**

Stopping smoking is one of the best things you can do for your health. Would you like help to quit? ☐ **Yes** ☐ **No**

If yes, do you consent to being referred to the free Southern Stop Smoking Service? ☐ **Yes** ☐ **No**

Would you like a free consultation with one of our nurses to welcome you to the practice and update your clinical details? ☐ **Yes** ☐ **No**

MY DECLARATION OF ENTITLEMENT AND ELIGIBILITY

I am entitled to enrol because I am residing permanently in New Zealand: ☐ **Yes** ☐ **No**
(The definition of residing permanently in NZ is that you intend to be resident in NZ for at least 183 days in the next 12 months)

I am eligible to enrol because:

☐ I am a New Zealand Citizen.

If you are **NOT a New Zealand Citizen** please tick which eligibility applies to you below:

☐ I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010).
☐ 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 two consecutive years.
☐ I have a work visa/permit and can show that I am able to be in New Zealand for at least two years (previous permits included).
☐ I am an interim visa holder who was eligible immediately before my interim visa started.
☐ 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.
☐ 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.
☐ 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 am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme.
☐ I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a NZ university under the Commonwealth Scholarship and Fellowship Fund.

* **I confirm** that, if requested, I can provide proof of my eligibility: ☐ **Yes** ☐ **No**

MY AGREEMENT TO THE ENROLMENT PROCESS (PARENT OR CAREGIVER TO SIGN IF YOU ARE UNDER 16)

- **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 Wanaka Medical Centre I will be included in the enrolled population of WellSouth Primary Health Network, 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 access to 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. (Available on request).
- **I understand** that I am required to pay on the day for each visit. If I do not pay on the day of consultation, an account will be sent to me. Monthly accounts incur a $5 fee. **Payment is expected by the 20th of the month following. All costs incurred in the collection of overdue accounts will be payable by the debtor.**
- **I have read and agree** with the Use of Health Information Statement. The information I have provided on the Enrolment form will be used to determine eligibility to recieve 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 understand** that the practice may share my health information between healthcare providers using HealthOne, a secure system for storing electronic patient records and that all information is kept confidential and checks are in place to monitor all access.
- **I understand** that further information on HealthOne is available from the practice on request.
- **I agree** to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

SIGNATORY DETAILS

I have read and agree to the above conditions of enrolment.

Signature:

Date:

AUTHORITY DETAILS*

Full Name of Authority:

Contact Phone:

Relationship:

Detail the basis or authority (eg: parent of child under 16):

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

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EDI: wanaka, **GP2GP:** Dr Andrew McLeod, MC No: 12523

PATIENT NOTES REQUEST

Note: If patient is over 16 years of age, they must complete and sign their own form.

Family Name:
First Name(s):
Date of Birth:
NHI:

Previous Practice Name: ____
(New Zealand Only)

Address: ____

____

Phone: ____

Fax: ____

In order to get the best coordinated clinical care, I agree to Wanaka Medical Centre obtaining my medical records from my previous practice. I understand I will also be removed from the register of my previous practice.

Signed: ____

Dated: ____