

# THAMES MEDICAL CENTRE PATIENT ENROLMENT FORM

Each person 16 years or over to complete and sign own form (under 16 form to be completed by parent/caregiver)

**\*Must be completed**

NHI: (Office Use Only)\*

## 1. Personal Details:

Title:

Family Name:\*

First Name/s:\*

Preferred Name:

Other name/s known by and/or Maiden name:

Date of Birth:\*

Gender:\*

Please Tick ✓

Account holder:

Please Tick ✓

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M		F	
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Y		N	
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## 2. Contact Details:

**Physical Address:\***

Unit/House

No:

Street:

Suburb:

Town/City:

Postcode:

Home Phone:

Work Phone:

Mobile Phone:

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Email Address:

**Postal Address:**

(If different from Physical Address)

PO Box/Unit/  
House No:

Street:

Suburb/Rural Delivery:

Town/City:

Postcode:

Preferred Contact Methods: Please Tick ✓

Consent to use text messaging:

Secure Email		Text		Landline		Cell Phone		Post	
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Yes / No Please Circle One

## 3. Ethnicity\*:

WHICH ETHNIC GROUP DO YOU BELONG TO? (YOU MAY SELECT UP TO THREE ETHNICITIES):

NZ European/Pakeha	11	
Maori (please state iwi)	21	

Tokelauan	35	
African	53	

Not Stated	99	
Declined	98	

Samoan	31	
Cook Island Maori	32	
Tongan	33	
Niuean	34	
Chinese	42	
Indian	43	
Other (please state)	54	

Other Pacific	37	
Middle Eastern	51	
South East Asian	41	
Other Asian	44	

Latin American/Hispanic	52	
Fijian	36	
Other European	12	

#### 4. Residential Status:

Country of Birth:\*

If New Zealand is your country of birth, go to Q5

If you are not born in NZ  
are you a NZ resident?

Yes

☐

No

☐

Are you on a working  
Visa?

Yes

☐

No

☐

Are you a refugee:

Yes

☐

No

☐

Visa/Permit Sighted: (Office Use  
Only)

Yes

☐

No

☐

#### 5. Next of Kin/Emergency Contact Details:

Title:  Family Name :

First Name/s:

Relationship:

Physical Address:

Unit/House No:  Street:

Suburb:

Town/City:

Postcode:

Day Phone:

Mobile Phone:

#### 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:

#### 8. Smoking Status:

Smoking status is an important factor influencing health. Please tick the space that applies for those aged 15 and over:

☐

Never smoked

☐

In the past smoked daily for more than a year but  
no longer smoke

☐

Currently a smoker

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

Dr Brendon Aish	<input type="checkbox"/>	Dr John Cargill	<input type="checkbox"/>	Dr Sue Genner	<input type="checkbox"/>
Dr Stephen Gunn	<input type="checkbox"/>	Dr Kerry Hennessy	<input type="checkbox"/>	Dr Adrian Ireland	<input type="checkbox"/>

**I am entitled to enrol** because I am residing permanently in New Zealand<sup>1</sup> and meet one of the following eligibility criteria:

	Please circle one
a) I am a New Zealand citizen <b>OR</b>	Yes / No
b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	Yes / No
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	Yes / No
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)	Yes / No
e) I am an interim visa holder who was eligible immediately before my interim visa started	Yes / No
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	Yes / No
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	Yes / No
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	Yes / No
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)	Yes / No
j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	Yes / No
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.	Yes / No

**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 years)

**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 Midlands Regional Health Network Charitable Trust, 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 Midlands Regional Health Network Charitable Trust, 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.

	/   / Day   Month   Year	
<b>SIGNATURE*</b>	<b>DATE*</b>	
<b>OR signed by AUTHORITY<sup>2</sup></b>		
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):		

<sup>1</sup> The definition of residing in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months.

<sup>2</sup> An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.