



*Compulsory Fields. Must be Filled | Anyone over age of 16 years must complete their own enrolment form

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: * DAY MONTH YEAR		PLACE & COUNTRY OF BIRTH: *	OCCUPATION & EMPLOYER	
RESIDENTIAL ADDRESS*	STREET NUMBER	NAME OF STREET	SUBURB	CITY/TOWN POST CODE
POSTAL ADDRESS	HOME PHONE:			
	WORK PHONE:			
MOBILE	TICK BOX FOR NO TXTS <input type="checkbox"/>		COMMUNITY SERVICE CARD	CARD NUMBER EXPIRY DATE
EMAIL	TICK BOX FOR NO EMAILS <input type="checkbox"/>		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

CHINESE

INDIAN

OTHER (SUCH AS FILIPINO, VIETNAMESE, JAPANESE, AUSTRALIAN, AMERICAN, DUTCH, ITALIAN ETC.) Please State:

*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!*



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**

How did you come to find Northpoint Medical Centre?

Website Google Facebook Walking by Friend/Family/Colleague

Marketing by Northpoint Other (please state) :

*** My Declaration of Entitlement and Eligibility ***

Please read this sheet carefully to identify your criteria which will provide for your eligibility for funded health services

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	<input type="checkbox"/>
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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)	<input type="checkbox"/>
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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)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
e	I am an interim visa holder ¹ who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>

I confirm that I can provide proof of my eligibility	<input type="checkbox"/>	Evidence sighted and scanned (<i>Office use only</i>)
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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 / First level health care services.

I understand that by enrolling with this practice I will be included in the enrolled population of **Primary Health Organisation (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.

<p style="text-align: center; color: blue;">I acknowledge that I have reviewed the relevant fees displayed/provided to me for services rendered. I acknowledge that all fees must be paid in full on the day unless prior arrangement is made with Management.</p> <p style="text-align: center; color: blue;">An administration fee will be added to all outstanding accounts at the end of each month. A further fee will be incurred if the overdue amount is sent to the Debt Collector including their collection fee.</p>	<input type="checkbox"/> <small>Tick Here</small>
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Signatory Details	*Signature	*Day / Month / Year	<input type="checkbox"/> <small>Self-Signing</small>	<input type="checkbox"/> <small>Authority</small>
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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 <small>(where signatory is not the enrolling person)</small>	Full Name	Relationship	Contact Phone
Authority Details	Basis of authority (e.g. parent of a child under 16 years of age)		

¹ If a person has an interim visa this means they are waiting for Immigration to finish processing an application as Immigration issues interim visas if the old visa has run out, but the new visa is still being processed. To determine the eligibility of an interim visa holder you should look at what their eligibility status was immediately prior to being issued the interim visa. For example, the person had a two-year work permit and has been issued with an interim visa while waiting for their application for another two-year work permit to be processed. Immigration usually issues Interim visas in a letter form.