# SAINT PATRICKS SQUARE MEDICAL CENTRE

**Level 2, 33 Wyndham Street, City**
**Ph: 09 302 2496 Fx: 09 302 2431**
**EDI: Comtrust**

| **Title** Mr Mrs Ms Miss Dr | | | | **Place / Country of birth:** |
|---|---|---|---|---|
| **Names** * | First Name/s* | Last Name* | **Date of Birth*** | ________/________/________ Day Month Year |
| **Preferred Name** | | | **NHI:** | |
| **Other Names Known By** (e.g. maiden name) | | | **Gender*** | ☐ Male ☐ Female |
| **Physical Address** | Street or Rapid (rural) number | Name of Street | **How did you find out about us?** | |
| | Suburb | | **Community Services Card** | **YES / NO** |
| | City/Town | Postcode | | **Card Number** **Expiry Date** |
| **Postal Address** (If different from above) | | | **High User Health Card** | **YES / NO** |
| | | | | **Card Number** **Expiry Date** |
| **Day Phone** | | | **Mobile** | |
| **Night Phone** | | | **Email** | |

| **Emergency Contact** * **Next of Kin** | **Which ethnic group do you belong to?** * | | (Tick the spaces which apply to you) | |
|---|---|---|---|---|
| | New Zealand European | | Niuean | |
| Name of person to contact: ____________________ | Maori | | Chinese | |
| Relationship to you: ____________________ | Samoan | | Indian | |
| Ph Number/s: ____________________ | Cook Island Maori | | Other (Please state) | |
| Address: ____________________ | Tongan | | ____________ | |

**Dependents listed on this form will also be enrolled in the PHO as long as I am legally entitled to sign on their behalf (see over)**

| NHI | First Names | Family Name | Gender | Ethnicities | Date of Birth |
|---|---|---|---|---|---|
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**Transfer of Records***

In order to get the best care possible, I agree to Saint Patricks Square Medical Centre obtaining my /our medical records from my previous Doctor. I also understand that I will be removed from their practice register

Yes ☐ No ☐ Not applicable ☐

Previous Doctor's Name: ______________________________ Address ______________________________

GP Ph No: ________________ Patients Signature: ______________________________ Date: ______________

**RECEPTION TO COMPLETE BEFORE SCANNING INTO MEDTECH**

Transfer Request Date Faxed: ______________ GP Fax No: ________________ Staff Name: ________________

**I intend to use St Patricks Square 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 meet one of the following criteria: I am a New Zealand Citizen **AND** I am currently residing permanently in New Zealand **OR**

a. I hold a residence permit **AND** have been in New Zealand for at least 2 years, or hold a current returning residents visa **OR**
b. I am an Australian citizen or an Australian permanent resident able to show that my total stay in New Zealand is or will be at least 2 years **OR**
c. I am a work permit holder able to show that I am able to be in New Zealand for at least 2 years **OR**
d. I am under 18 and in the care and control of my parent/legal guardian/adopting parent, who is one of a–d above.
e. I am a refugee **OR** in the process of applying or appealing for refugee status **OR**
f. I am a Ministry of Education Foreign Language Teaching Assistant
g. I am on a New Zealand Official Development Assistance or Commonwealth scholarship (or my partner/parent is a NZODA scholarship holder)

**I confirm** that, if requested, I can provide proof of my eligibility.

## My agreement to the enrolment process

**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 National Hauora Coalition which this practice belongs to, and my name address and other identification details will be included on both Saint Patricks Square Medical and The National Hauora Coalition 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 National Hauora Coalition, and their contact details.

**I have read and I agree** with the Health Information Privacy Statement (overleaf).

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

| | / / <br> Day Month Year |
|---|---|
| **SIGNATURE** | **DATE** |

**OR Signed by AUTHORITY**

| Full Name of Authority | Contact Phone Number | Relationship |
|---|---|---|
| Address | Signature of Authority | / / <br> Day Month Year |
| Detail the basis of authority (e.g. parent of a 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.