

# Fiordland Medical Practice



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## ENROLMENT FORM

<b>ENROLMENT FORM</b>				<b>NHI</b>			
<b>Title</b>	Mr Ms Dr	Mrs Miss	<b>First Name(s)</b>			<b>Family Name</b>	
<b>Preferred Name</b>					<b>Other Names Known By</b> (e.g. maiden name)		
<b>Gender</b>	<b>Male</b>		<b>Female</b>		<b>Place / country of birth</b>		
<b>Physical Address</b> <b>Note that we need Rapid Numbers and Road Address.</b> <b>R D not sufficient.</b>	Street or Rapid (rural) number		Name of Street		<b>Date of Birth</b>	<div> <div></div> <div></div> <div></div> </div> <div>Day Month Year</div>	
	Suburb				<b>Community Services Card</b>	<b>YES NO</b>	
	City/Town		Postcode			<b>Card Number</b> <b>Expiry Date</b>	
<b>Postal Address</b> <b>MANAPOURI MANDATORY</b>					<b>High User Health Card</b>	<b>YES NO</b>	
						<b>Card Number</b> <b>Expiry Date</b>	
<b>Contact Details</b>	<b>Day Phone</b>		<b>Night Phone</b>		<b>Cell Phone*</b>		<b>Email*</b>
<b>Emergency contact</b> <b>Eg: next of kin</b>	<b>Name of person to contact</b>		<b>Relationship</b>		<b>Phone number</b>		<b>Next of Kin Mobile or email</b>

<b>Which ethnic group(s) do you belong to?</b> Mark the space or spaces which apply to you		<b>Occupation</b>			
New Zealand European				<b>Employer name</b>	
Māori - iwi					
Samoan				<b>Employer address</b>	
Cook Islands Maori Tongan				<b>Smoker Non Smoker</b> <b>EX Smoker</b>	
Niuean				<b>Would you like to quit smoking?</b>  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 No Not applicable  <b>Previous Doctor's Name:</b> <b>Previous Doctor's Address</b> (NZ Only) :	
Chinese					
Indian					
Other such as DUTCH, JAPANESE, TOKELAUAN. Please state:					

<b>Dependants listed on this form will also be enrolled with Southern WellSouth PHO and I am legally entitled to sign on their behalf (see over)</b>					
<b>NHI</b>	<b>First Names</b>	<b>Family Name</b>	<b>Gender</b>	<b>Ethnicity/Ethnicities</b>	<b>Date of Birth</b>

## Enrolment in the Practice / Primary Health Organisation (PHO)

I intend to use **Fiordland Medical Practice** 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 for more than six months of every year and meet one of the following criteria **Please tick appropriate box:**

- 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 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 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 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 contact details or eligibility. I have seen and agree to Fiordland Medical Practice's terms of trade (displayed on wall).

I understand that medical reminders (recalls) and other health info may be sent to me via email and/or SMS text message.

	Day / Month / Year
<b>SIGNATURE</b>	<b>DATE</b>

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

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):		