



**SILVERSTREAM
MEDICAL CENTRE**

42 Silverstream Bvd, Silverstream,
Kaiapoi. 7630
Ph: 03 595 1489 Fax: 03 327 0843

ENROLMENT FORM

September 2018

***Mandatory Details**

*Anyone over the age of 16 years must complete
their own enrolment form*



Practice Name* Silverstream Medical Centre	Doctor Name NZMC	EDI: silmedic	*NHI (Office use only)
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Legal Name*	(Title)	*Given Name	*Other Given Name(s)	*Family Name
Other Name (s)	Other Name		Other Given Name(s)	Other Family Name (eg. maiden name)
Preferred Name	Preferred Name		*Date of Birth Day / Month / Year of Birth	*Place of Birth
Gender*	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)	Occupation

Usual Residential Address*	House (or RAPID) Number and Street Name	Suburb	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb	Town / City and Postcode

Contact Details	Mobile Phone	Home Phone	Email Address
Emergency Contact*	Name	Relationship	Mobile (or other) Phone

Community Services Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number		
High User Health Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number		
Smoking Status*	<input type="checkbox"/> Smoker	If yes, would you like any support to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Ex-Smoker Less than 15months ago	<input type="checkbox"/> Ex-Smoker More than 15months ago	<input type="checkbox"/> Never Smoked

Ethnicity Details* Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	<input type="radio"/> New Zealand European	Iwi: _____ Do you give consent for the clinical team to access your medical records from other health providers via "HealthOne"? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you happy to receive SMS Text messages? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have any allergies? Yes <input type="checkbox"/> <input type="checkbox"/> Please specify: _____ No <input type="checkbox"/>
	<input type="radio"/> Maori	
	<input type="radio"/> Samoan	
	<input type="radio"/> Cook Island Maori	
<input type="radio"/> Tongan		
<input type="radio"/> Niuean		
<input type="radio"/> Chinese		
<input type="radio"/> Indian		
<input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state; <input type="text"/>		

Transfer of Records	<i>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.</i>		
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor and/or Practice Name	Address / Location	

My declaration of entitlement and eligibility*

I am entitled to enrol because I am residing permanently in New Zealand.

The definition of residing permanently in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months

I am eligible to enrol because:

a	I am a New Zealand citizen <i>(If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below)</i>	<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 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, if requested, I can provide proof of my eligibility*	<input type="checkbox"/>	Evidence sighted (<i>Office use only</i>)	<input type="checkbox"/>
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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 / health care services.

I understand that by enrolling with this Practice I will be included in the enrolled population of Pegasus Health Charitable Ltd PHO (Primary Health Organisation) 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 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 agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

Signatory Details*	Signature	Day / Month / Year	<input type="checkbox"/>	<input type="checkbox"/>
			Self Signing	Authority

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 <i>(where signatory is not the enrolling person)</i>	Full Name	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age)		