Morrinsville Medical Centre

17 Canada Street, Morrinsville
Ph: 07 889 5126
Email: info@mormc.co.nz

PATIENT ENROLMENT FORM

Each Person 16 years or over to complete and sign own form
Each enrolled patient must have their own enrolment form

***Must be completed** NHI: (Office Use Only)* Chart No.:

1. Personal Details:

Title: **Family Name:** **First Name/s:***

Preferred Name: **Other name/s known by and/or Maiden name:**

Date of Birth:* **Gender:*** **Gender Self Identified:** **Sex at birth:**

M/F **M/F**

Account holder: Please Tick ✓

Y **N** ✓

Place of birth:

2. Contact Details:

Physical Address:*

Unit/House No: **Street:** **Suburb:**

Town/City: **Postcode:**

Home Phone: **Work Phone:** **Mobile Phone:**

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 ✓

Secure Email **Text** **Landline** **Cell Phone** **Post**

Consent to use text messaging:
Yes / No Please Circle One

Contact Methods:

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	
EDI: morrinmc		

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	☐
Samoan	31	☐
Cook Island Maori	32	☐
Tongan	33	☐
Niuean	34	☐
Chinese	42	☐
Indian	43	☐
Other Ethnicity (please state)	61	☐

4. Residential Status:A PASSPORT OR BIRTH CERTIFICATE MUST BE PROVIDED ON ENROLMENT

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 a refugee: Yes ☐ No ☐

Are you on working Visa? 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: **Postal Code:**

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

Approximate Quit Date _____

Smoking is hugely negative on your good health. In most cases, you will experience the benefits of quitting immediately.

If you currently smoke, would you like some help to quit?

☐ Yes ☐ No

Signed Authority:

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

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	☐

	Please encircle
I am eligible to enrol because: a) **I am a New Zealand citizen** (If yes, encircle yes and proceed to I confirm that, if requested, I can provide proof of my eligibility below)	Yes / No
If you are <u>not</u> a New Zealand citizen please encricle which eligibility criteria applies to you (b–k) below: 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*	☐	**Evidence sighted (Office use only)**	☐

MY AGREEMENT TO THE ENROLMENT PROCESS:

(NB Parent or caregiver to sign if you are under 16 years)

*Patients 16 and over are automatically enrolled onto our patient portal MyIndici

I intend to use 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 **Morrinsville Medical Centre** I will be included in the enrolled population that the Primary Health Organisation (PHO) this practice belongs to , and my name address and other identification details will be included on 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 2020.
I understand that the Practice participates in the 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 or opt out of the survey by informing the Practice. The survey provides important information that is used to improve the health services.
I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

	/ / Day Month Year
SIGNATURE	**DATE**

OR signed by AUTHORITY2

Full Name of Authority:	Contact Phone Number:	Relationship:
Address:	Signature of Authority:	/ / Day Month Year

1 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.
2 An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

EACH PERSON 16YRS OR OVER TO COMPLETE AND SIGN OWN FORM

In order to receive the best care possible, I agree to Morrinsville Medical Centre obtaining my medical records from my previous doctor. I also understand that I will be removed from their patient register.

Previous Medical Centre:_____
Address of Medical Centre:_____
Phone:_____ Fax:_____

Please transfer the medical records for the following people to Morrinsville Medical Centre.

Family Name	Given Names	DOB or NHI

Our practice is able to receive and would prefer electronic GP2GP notes transfer.
EDI: morrinmc

Dr Dominique Hite NZMC59378 o
Dr Naresh Parsotam NZMC 14107 o
Dr Gillian Brown NZMC 11205 o
Dr Michel Arnephy NZMC42646 o
Dr Olof Rydin NZMC 42995 o

Signed: _____ **Date:** _____

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PO Box 86
Morrinsville 3300

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