auckland family medical centre

Auckland Family Medical Centre
94 Remuera Road
Remuera

ProCare

Phone: 09 524 6249 | Email: reception@aucklandfamily.co.nz | Website: https://www.auckland-family.com/

Fields with * are compulsory	***Anyone over age of 16 years must complete their own enrolment form***	**NHI** *(Office use only)*

Name	Title	* Given Name	* Other Given Name(s)	* Family Name
Other Name(s) (eg. maiden name) Please tick the name you prefer to be known as				
Birth Details		* Day / Month / Year of Birth	* Place of Birth	* Country of birth
Gender		* ☐ Male ☐ Female ☐ Gender Diverse (please state)		Occupation

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

Contact Details	Mobile Phone	Home Phone	Work Phone	Email
***Preference for communication from the practice e.g. recalls, surveys, newsletters** ☐ Email ☐ Text ☐ Phone ☐ No communication				
Emergency Contact	Name		Relationship	Mobile (or other) Phone

Ethnicity Details** Which ethnic group(s) do you belong to? ***Tick the space or spaces which apply to you	**New Zealand European** **Māori** **Iwi:**_____ **Hapū:**_____ **Samoan** **Cook Island Maori** **Tongan** **Niuean** **Chinese** **Indian** **Other** (such as Dutch, Japanese, Tokelauan). Please state	**Community Services Card**	☐ Yes	☐ No
		Day / Month / Year of Expiry	Card Number	
		High User Health Card	☐ Yes	☐ No
		Day / Month / Year of Expiry	Card Number	
		Do you Smoke?	☐ Yes ☐ No (ex-smoker)	☐ Never
		Disabilities:		
		Comments:		

* My declaration of entitlement and eligibility *

I am entitled to enroll 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 enroll 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)*	☐

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)	☐
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	☐
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)	☐
e	I am an interim visa holder who was eligible immediately before my interim visa started	☐
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	☐
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	☐
h	I am a NZ Aid Program student studying in NZ and receiving Official Development Assistance funding (or their partner or child under 18 years old)	☐
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	☐
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	☐

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

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 the Primary Health Organization this practice belongs to 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, which also includes information on the security and privacy of health data that is collected. 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**	☐ 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 *(Where signatory is not the enrolling person)*	Full Name	Relationship	Contact Phone
Authority Details	Basis of authority (e.g. parent of a child under 16 years of age)		

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Transfer of Records

Patient Request for Transfer of Medical Records.

Patient Name: _____
Date of Birth: _____
Current Address: _____
Contact Number: _____

Patient Authorization:

I, the undersigned, hereby request the transfer of my medical records and ongoing care from my current healthcare provider to the new healthcare provider **Auckland Family Medical Centre**.

I authorize my current provider to release all relevant medical information to ensure a smooth transition of care.
(Please provide the name of your current Practice and GP)
_____

I understand that the transfer process may take some time and agree to coordinate with both my current and new provider to complete the necessary steps for this transfer. I also acknowledge that I will be removed from my previous practice register.

Patient Signature: _____
Date: _____

Auckland Family Medical Centre GP2GP Transfer Information:
EDI: auckfamc
Email: reception@aucklandfamily.co.nz

Our doctors:

Name	**NZMC #**
Dr John McCartie	***13621***
Dr Phillipa Murray	***18233***
Dr Sheelagh James	***16157***
Dr Victor Ji	***70929***
Dr Mirjana Janjic	***22027***
Dr Glenn Neo	***67545***