# GP CENTRAL

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## Enrolment Form

**OFFICE USE ONLY**

| | | | |
|---|---|---|---|
| ▫ Dr Caitlin Corlett | NZMC: 83998 | ▫ Dr Terrillian Hui | NZMC: 75705 |
| ▫ Dr Ben Liu | NZMC: 40679 | ▫ Dr Queenie Son | NZMC: 59705 |
| ▫ Dr Richard Lowe | NZMC: 71629 | ▫ Dr Logitha Sritharan | NZMC: 76063 |
| ▫ Dr Gary MacLachlan | NZMC: 15793 | ▫ Dr Michael Epiha | NZMC: 84318 |
| ▫ Dr Sam Burridge | NZMC: 71551 | ▫ Dr Calum Cunningham | NZMC: 78477 |
| ▫ Dr Bobae Lee | NZMC: 84372 | ▫ OTHER: | NZMC: |

**NHI :**

| | | | |
|---|---|---|---|
| **Name** | Family Name (Surname) | Given Name (First Name) | Other Given Name(s) |
| Please tick the name you prefer to be known as | | | |
| **Birth Details** | Day / Month / Year | Place of Birth | County of Birth |
| **Gender** | ☐ Male | ☐ Female | ☐ Gender diverse / Occupation |
| **Usual Residential Address** | e.g. 223 Stoddard Road, Mt Roskill, Auckland 1041 | | |
| **Postal Address** | | | |
| **Contact Details** | Mobile phone | Home phone | Email address |
| **Emergency Contact** | Name | Relationship | Phone |
| **Transfer of Records** | *In order to get the best care possible, I agree to GP Central obtaining my records from my previous doctor. I also understand that I will be removed from my previous GP practice's register.* | | |
| | ☐ Yes, please request transfer of my records | ☐ No transfer | ☐ Not applicable |
| | Previous Doctor's name and Clinic's name/address: | | |
| | Signature: | | |

| **Ethnicity Details** | | | |
|---|---|---|---|
| Which ethnic group(s) do you belong to? **Tick the space or spaces which apply** | ☐ New Zealand European<br>☐ Māori<br>Iwi: _____<br>Hapū: _____<br>☐ Samoan<br>☐ Cook Island Māori<br>☐ Tongan<br>☐ Niuean<br>☐ Chinese<br>☐ Indian<br>☐ Other (such as Dutch, Japanese, Tokelauan). Please state: | Do you agree to receive texts? | ☐ Yes ☐ No |
| | | Community Services Card | ☐ Yes ☐ No |
| | | Card number and expiry: | |
| | | High User Health Care | ☐ Yes ☐ No |
| | | Card number and expiry: | |
| | | Do you smoke? | ☐ Never ☐ Ex-smoker ☐ Yes |
| | | **Register for MyIndici?** Secure **patient portal** - to access your medical records and manage your health online | ☐ Yes ☐ No |

# Declaration of Entitlement and Eligibility

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|---|---|
| I am entitled to enrol because I am residing permanently in New Zealand<br>*(the definition of residing permanently in NZ is that you intend to be resident in NZ for at least 183 days in the next 12 months)* | ☐ |

**I am eligible to enrol because:**

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|---|---|
| a) I am a New Zealand Citizen<br>*(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:**

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|---|---|
| b) I hold a resident visa or permanent resident visa (or a residence permit if issues before December 2010) | ☐ |
| c) I am an Australian citizen or Australian permanent resident<br>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<br>(previous permit 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<br>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<br>in clauses a - f above OR in the control of the Chief Executive of the Ministry of Social Development | ☐ |
| h) I am in NZ Aid Programme student studying in NZ and receiving Official Development Assistance funding<br>(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<br>and receiving funding from a New Zealand University under the Commonwealth Scholarship and Fellowship Fund | ☐ |

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| **I can confirm that, if requested, I can provide proof of eligibility** | ☐ | Evidence sighted *(office use only)* |

## My agreement to the enrolment process

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

**I intend to use this practice** as my regular on 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 with the Primary Health Organisation (PHO) this practice belongs to, and my name, address and other identification details will be included in the Practice, PHO and National Service Registers.
**I understand** that if I visit another healthcare provider where I am 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 | ☐ 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***

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|---|---|---|---|
| **Authority Details**<br>(when signatory is not the enrolling person) | Full Name | Relationship | Contact Phone |
| | Basis of authority (e.g. parent of a child under 16 years of age) | | |