

# ENROLMENT FORM

368 Albany Highway Albany Auckland 0632 P: 09 4158959 F: 09 4158139 EDI: albanyfm E: reception@albanydocs.co.nz



#### Provider: GP2GP Dr John Kyle 11756: Dr Philip Gluckman 11900: Dr Harriet Martin 16946: Dr Grace Beshara 43840: Dr Samar Hamid 77139: Dr Lee-Chen Gan 46186: Dr Helen Sharp 80858: Dr Saira Goroo 23874 NHI:

Other Name(s) (eg. maiden name) (prefered name)       Image: State in the image: State	Legal	(T:+ -)	Civer News		Family Nama		
(reg. mailen name) /prefered name)       Day / Month / Year of Birth       Place of Birth       Country of birth         Gender       Day / Month / Year of Birth       Place of Birth       Country of birth         Gender       Maile       Female       Gender diverse (please state)       Occupation         Optional       Marital status       Occupation       Town / City and Postce         Usual Residential Address       House (or RAPID) Number and Street Name       Suburb/Rural Location       Town / City and Postce         Postal Address       House Number and Street Name or PO Box Number       Suburb/Rural Delivery       Town / City and Postce         Contact Details       Mobile Phone       Home Phone       Email Address         Emergency       Contact /NOK       Name       Relationship       Mobile (or other) Phone         Community Services Card       Image: Day / Month / Year of Expiry       Card Number       Mobile (or other) Phone         High User Health Card       Image: Day / Month / Year of Expiry       Card Number       Image: Day / Month / Year of Expiry       Card Number         Transfer of       In order to get the best core possible, I agree to the Practice obtaining my records from my previous Doctor envioled at 1 practice at a time in NZ       Image: Day / Month / Year of Expiry       Card Number         Ethnicity       Image: Day / Month / Year of Expiry </th <th>Name Other Nam</th> <th>(Title)</th> <th>Given Name</th> <th>Middle Name(s)</th> <th>Family Name</th> <th></th>	Name Other Nam	(Title)	Given Name	Middle Name(s)	Family Name		
Day / Month / Year of Birth       Place of Birth       Country of birth         Gender       Image	(eg. maiden name						
Gender       Image       Image <t< th=""><th>Birth Detail</th><th>ls</th><th></th><th></th><th></th><th></th></t<>	Birth Detail	ls					
Male       Female       Gender diverse (please state)         Optional       Marital status       Occupation         Usual Residential Address       House (or RAPID) Number and Street Name       Suburb/Rural Location       Town / City and Postor         Postal Address (if different from above)       House (or RAPID) Number and Street Name or PO Box Number       Suburb/Rural Delivery       Town / City and Postor         Contact Details       Mobile Phone       Home Phone       Email Address         Emergency Contact /NOK       Mame       Day / Month / Year of Expiry       Card Number         Migh User Health Card       Yes       No       Day / Month / Year of Expiry       Card Number         Transfer of Records       In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor (within NZ only). I also understand that I will be removed from their practice register, as I am only able to enrolled at 1 practice at a time in N2         Previous Doctor and/or Practice Name       Address / Location       Invert applicable         Previous Doctor and/or Practice Name       Address / Location       Primary       Language       IWI:         Which method group(r)       New Zealander NZ Maori (state lwi) Samoan       Not ransfer       Not applicable         Previous Doctor and/or status (if over 14)       Never smoked			Day / Month / Year of Birth	Place of Birth	Country of birth		
Marital status       Occupation         Usual Residential Address       House (or RAPID) Number and Street Name       Suburb/Rural Location       Town / City and Postor         Postal Address (if different from above)       House Number and Street Name or PO Box Number       Suburb/Rural Location       Town / City and Postor         Contact Details       Mobile Phone       Home Phone       Email Address         Emergency Contact /NOK       Name       Relationship       Mobile (or other) Phone         Community Services Card         No       Day / Month / Year of Expiry       Card Number         High User Health Card         Day / Month / Year of Expiry       Card Number         Transfer of Records       In order to get the best care possible, 1 agree to the Practice obtaining my records from my previous Doctor enrolled at 1 practice at a time in NZ	Gender		Male Female Gende	er diverse (please state)			
Address       House (or RAPID) Number and Street Name       Suburb/Rural Location       Town / City and Postor         Postal Address (if different from above)       House Number and Street Name or PO Box Number       Suburb/Rural Delivery       Town / City and Postor         Contact Details       Mobile Phone       Home Phone       Email Address         Emergency Contact /NOK       Mobile Phone       Home Phone       Email Address         Community Services Card       Home Phone       Relationship       Mobile (or other) Phone         Ves       No       Day / Month / Year of Expiry       Card Number       Mobile (or other) Phone         Transfer of Records       In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor (within NZ only). I also understand that I will be removed from their practice register, as I am only able to enrolled at 1 practice at a time in NZ         Yes, please request transfer of my records       No transfer       Not applicable         Previous Doctor and/or Practice Name       Address / Location       IWI:         Which ethnic group(b)       New Zealander NZ Maori (state Iwi)       Samoan Cook Island Maori       Smoking status (if over 14)       Never smoked	-			Occupation			
(if different from above)       House Number and Street Name or PO Box Number       Suburb/Rural Delivery       Town / City and Postor         Contact Details       Mobile Phone       Home Phone       Email Address         Emergency Contact /NOK       Name       Relationship       Mobile (or other) Phone         Community Services Card       Image: Preside the provide			House (or RAPID) Number and Street Name		Suburb/Rural Location Town / City and Postcode		
Mobile Phone       Home Phone       Email Address         Emergency Contact /NOK       Name       Relationship       Mobile (or other) Phone         Community Services Card       Image: Previous Card       Im							
Contact /NOK       Name       Relationship       Mobile (or other) Photometry         Community Services Card       Image: Service Card Number       Service Card Number         High User Health Card       Image: Service Card       Image: Service Card Number       Image: Service Card Number       Card Number         Transfer of Records       In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor (within NZ only). I also understand that I will be removed from their practice register, as I am only able to enrolled at 1 practice at a time in NZ         Yes, please request transfer of my records       No transfer       Not applicable         Previous Doctor and/or Practice Name       Address / Location       Not applicable         Which ethnic group(s) do you belong to?       NZ Maori (state Iwi)       How long have you lived in NZ:       Mobie (or other)         Trick the space or spaces       Cook Island Maori       Smoking status (if over 14)       Never smoked			Mobile Phone	Home Phone	Email Address		
Community Services Card       Image: Previous Doctor and/or Practice Name       Image: Previous Doctor and/or Practice Name       Image: Previous Doctor and/or Practice Name         High User Health Card       Image: Previous Doctor and/or Practice Name       Image: Previous Doctor and/or Practice Name       Image: Previous Doctor and/or Practice Name         Transfer of Records       In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor (within NZ only). I also understand that I will be removed from their practice register, as I am only able to enrolled at 1 practice at a time in NZ         Yes, please request transfer of my records       No transfer       Not applicable         Previous Doctor and/or Practice Name       Address / Location       Not applicable         Which ethnic group(s) do you belong to?       Nz Maori (state lwi)       How long have you lived in NZ:         Track the space       Samoan       Smoking status (if over 14)       Never smoked					Deletionellie	Mahila (ay athay) Dhana	
High User Health Card       Yes       No       Day / Month / Year of Expiry       Card Number         Transfer of Records       In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor (within NZ only). I also understand that I will be removed from their practice register, as I am only able to enrolled at 1 practice at a time in NZ         Previous Doctor and/or Practice Name       No transfer       No transfer       Not applicable         Ethnicity Details       New Zealander       Previous Doctor (state lwi)       Primary       Language       IWI:         Which ethnic or spaces       NZ Maori (state lwi)       Samoan       Smoking status (if over 14)       Never smoked	contact /NOK		Name		Relationship	Mobile (or other) Phone	
Yes       No       Day / Month / Year of Expiry       Card Number         Transfer of Records       In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor (within NZ only). I also understand that I will be removed from their practice register, as I am only able to enrolled at 1 practice at a time in NZ         Yes, please request transfer of my records       No transfer       Not applicable         Yes, please request transfer of my records       No transfer       Not applicable         Previous Doctor and/or Practice Name       Address / Location       Not applicable         Which ethnic group(s) do you belong to?       NZ Maori (state Iwi)       Samoan       How long have you lived in NZ:         Tick the space or spaces which apply to       Cook Island Maori       Smoking status (if over 14)       Never smoked	Community Service			ay / Month / Year of Expiry	Card Number		
Records       (within NZ only). 1 also understand that 1 will be removed from their practice register, as I am only able to enrolled at 1 practice at a time in NZ         Yes, please request transfer of my records       No transfer         Previous Doctor and/or Practice Name       Address / Location         Ethnicity       Previous Doctor and/or Practice Name         Which ethnic group(s) do you belong to?       New Zealander         NZ Maori (state lwi)       Samoan         Cook Island Maori       Smoking status (if over 14)         Never smoked	High User Health C			ay / Month / Year of Expiry	Card Number		
Ethnicity Details Which ethnic group(s) do you belong to?     New Zealander NZ Maori (state lwi) Samoan Cook Island Maori     Primary Spoken:     Language Spoken:     IWI:       How long have you lived in NZ:     NZ:       Samoan     Samoan     Smoking status (if over 14)     Never smoked			In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor (within NZ only). I also understand that I will be removed from their practice register, as I am only able to be enrolled at 1 practice at a time in NZ				
Ethnicity       Primary       Language       IWI:         Details       New Zealander       Spoken:       IWI:         which ethnic group(s) do you belong to?       NZ Maori (state lwi)       How long have you lived in NZ:         Tick the space or spaces       Samoan       Cook Island Maori       Smoking status (if over 14)			Yes, please request transfe	r of my records	No transfer	Not applicable	
Ethnicity       Primary       Language       IWI:         Details       New Zealander       Spoken:       IWI:         which ethnic group(s) do you belong to?       NZ Maori (state lwi)       How long have you lived in NZ:         Tick the space or spaces       Samoan       Cook Island Maori       Smoking status (if over 14)							
Details       New Zealander         Which ethnic group(s) do you belong to?       NZ Maori (state lwi)         Tick the space       Samoan         or spaces       Cook Island Maori         which apply to       Smoking status (if over 14)			Previous Doctor and/or Practice Name		Address / Location		
belong to?     How long have you lived in N2:       Tick the space     Samoan       or     spaces       Which apply to     Cook Island Maori   Smoking status (if over 14) Never smoked	Details Which ethnic group(s) do you belong to? Tick the space or spaces		New Zealander			IWI:	
or spaces Cook Island Maori Smoking status (if over 14) Never smoked			Samoan		How long have you lived in NZ:		
					Smoking status (if over 14) Never smoked □ Ex-smoker □ Greater than 15months□ less than		
Indian       Would you like support to quit?       Yes □         Other Please state below:					Would you like support to quit? Yes $\Box$ No $\Box$		
I authorise Albany Family Medical Centre contact me via text message					contact me via text message I authorise Albany Family Medical Centre to		

### 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 (If yes, tick box and proceed to I confirm that, 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:
, <u> </u>		

b	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	
С	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 <b>OR</b> in the control of the Chief Executive of the Ministry of Social Development	
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)	
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 I have provided 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 I must pay my accounts on the day of consultation (including phone/email consults). Any outstanding balance of 90 days or more will be forwarded to Baycorp and that I will be liable for any collection costs.

I understand that by enrolling with Albany Family Medical Centre I will be included in the enrolled population of Comprehensive Care and my name, address and other identification details will be included on the Practice, CCPHO and National Enrolment Service Registers. Personal details and clinical notes may be shared with other Health Providers, or third-party requests as part of my healthcare e.g. ACC, Insurance Company requests, Ministry of Health, WINZ etc.

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 or informed about the benefits and implications of enrolment and the services this Practice and CCPHO provide.

I have read and I agree with the Use of Health Information Privacy 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 agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

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.

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	Full Name	Relationship	Contact Phone	
not the enrolling				
person) Basis of authority (e.g. parent of a child under 16 years of age)				