Level 8, 111 Customhouse Quay, Wellington
Phone: 04 912 2642 | Fax: 04 901 0920 | Email: admin@centralwellingtonmedical.co.nz

CENTRAL WELLINGTON MEDICAL CENTRE

ENROLMENT FORM - *Fields shaded are COMPULSORY*

NHI *(Office use only)*

Name (Title)	Given Name	Other Given Name(s)	Family Name
Other Name(s) (eg. maiden name) Please tick your preferred name			
Birth Details	Day / Month / Year of Birth	Place of Birth	Country of birth
Assigned Sex	☐ Male ☐ Female ☐ Intersex/Other	Pronouns	
Gender	☐ Male ☐ Female ☐ Gender Diverse (please state)		Occupation

Usual 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	**Can we text you?** ☐ **Can we email you?** ☐
Email Address:			
Emergency Contact	Name	Relationship	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. I also understand that I will be removed from their practice register, as I am only able to be enrolled at one practice at a time in New Zealand. *Please note, we can only transfer notes from practices within NZ*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Address / Location	

Please send to : **CENTRAL WELLINGTON MEDICAL, PO BOX 362, WELLINGTON 6140**

Or Electronically: **EDI is CWMEDCEN** **Dr Jacob Tan 59591**

Ethnicity Details

Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you.

- ☐ **New Zealand European**
- ☐ **Maori**

IWI: _____

- ☐ **Samoan**
- ☐ **Cook Island Maori**
- ☐ **Tongan**
- ☐ **Niuean**
- ☐ **Chinese (42)**
- ☐ **Filipino (41)**
- ☐ **Indian (43)**
- ☐ **Other European (12)**
- ☐ **Other** (such as Dutch, Japanese) 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		

SMOKING STATUS Please circle:

NON -SMOKER	CURRENT SMOKER	EX-SMOKER

PLEASE NOTE WE DO NOT RUN ACCOUNTS.

BY SIGNING THIS FORM YOU ACKNOWLEDGE that this practice is entitled to charge a fee for the health services it provides and **YOU AGREE TO PAY SUCH COSTS AT THE TIME OF CONSULTATION** and additional costs associated with the collection of unpaid accounts.

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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*	☐

AND I AM ELIGBILE TO ENROL because:

a	**I am a New Zealand citizen -** (incl. people from the Cook Islands, Niue or Tokelau) *(If yes, tick box and proceed to **I confirm that, if requested, I can provide proof of my eligibility** below)*	☐

OR: 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 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 am able to 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	☐
h	I am a NZ Aid Programme student studying in New Zealand and receiving Official Development Assistance funding (or my 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 ongoing provider of general practice / GP / health care service.

I understand that by enrolling with this practice I will be included in the enrolled population of this practice's Primary Health Organisation (PHO) Tu Ora Compass 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 and that by registering as a patient **I am agreeing to the Central Wellington Medicals *Finance Policy*** of which a full copy is available from reception and on the website.

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. NOTE: Tu Ora Compass – https://tuora.org.nz

I have read and I understand the Use of Health Information Privacy Statement. The information I have provided on this 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 understand that by signing this form I accept I will abide by the Code of Conduct and Finance Policies. Copies of these policies are available on our website.

SIGNATURE *Must be handwritten or e-signature*		**Day / Month / Year**

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
	Legal basis of authority (e.g. parent of a child under 16 years of age)		