Morrinsville Medical Centre

17 Canada Street, Morrinsville
Ph: 07 889 5126 **Fax:** 07 889 5123
Email: postmaster@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)*

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 ✓

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

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

Contact Methods:

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 Zealand1 and meet one of the following eligibility criteria:

	Please circle one
a) I am a New Zealand citizen **OR**	Yes / No
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.
Reception - eligibility proof sighted -copy taken / patient re enrolled and known to clinic Initial _____

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 / 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.

Health Information Privacy Statement

I understand the following:

Access to my health information

I have the right to access, and have corrected, my health information under Rules 6 and 7 of the Health Information Privacy Code 1994.

Visiting another doctor

If I visit another doctor who is not my regular doctor, I will be asked for permission to share information from the visit with my regular doctor or medical centre.

If I have a High User Health Card or Community Services Card and I visit another doctor who is not my regular doctor, he/she can make a claim for a subsidy, and the medical centre I am enrolled in will be informed of the date of that visit. The name of the medical centre I visited and the reason(s) for the visit will not be disclosed unless I give my consent.

Patient enrolment information

The information I have provided on the enrolment form will be:

- Held by the medical centre
- Used by the Ministry of Health to give me a National Health Index (NHI) number or update any changes
- Sent to Midlands Regional Health Network Charitable Trust (the Trust), which is a primary health organisation and to the Ministry of Health to obtain subsidised funding on my behalf. **This does not apply to casual patients**
- 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

Health information

Members of my health team may:

- Add to my health record during any services provided to me and use that information to provide appropriate care
- Share relevant health information to other health professionals who are directly involved in my care

Audit

With regards to financial audits, my health information may be reviewed by an auditor for checking a financial claim made by the medical centre, but only according to the terms and conditions of Section 22G of the Health Act or any subsequent applicable Act. I may be contacted by the auditor to check that services have been received. If the audit involves checking on health matters, an appropriately qualified health care practitioner will view the health records.

Health programmes

Health data relevant to a programme in which I am enrolled, such as breast screening, immunisation or diabetes, may be sent to the Trust or the external health organisation managing this programme.

Other uses of health information

Health information, which will not include my name but may include my NHI number, may be used by health organisations such as the district health board, the Ministry of Health or the Trust for the following purposes, as long as it is not used or published in a way that can identify me:

- Health service planning and reporting
- Monitoring service quality
- Payment

Research

My health information may be used for health research, but only if this has been approved by an ethics committee and will not be used or published in a way that can identify me.

Except as listed above, I understand that details about my health status or the services I have received will remain confidential within the medical centre unless I give specific consent for this information to be communicated.

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 Kerry Taylor NZMC 65915 o
Dr Gillian Brown NZMC 11205 o
Dr Naresh Parsotam NZMC 14107 o
Dr Michel Arnephy NZMC 42646 o
Dr Olof Rydin NZMC 42995 o
Dr Amin Uloom NZMC 61996 o

Signed: _____ **Date:** _____

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