ENROLMENT FORM
Glenfield Doctors on Chartwell

Address: 52 Chartwell Avenue, Glenfield Auckland 0629
Phone: 09-4412352 Fax: 09-4416176
EDI: **drjwilcx**
E: **gflddoctors@gmail.com**

comprehensive care

Note to Prior Provider: Please send records via GP2GP as follows: **Dr Jon Wilcox MCNZ 11213 (preferential contact)** **Dr Jong Keung (Tony) Ryu MCNZ 61936**	NHI *(Office use only)*

Legal Name	(Title)	Given Name	Middle Name(s)	Family Name
Other Name(s) (eg. Maiden/preferred)				Male☐ Female ☐ Other☐
Birth Details		DD / MM / YYYY	Place of Birth	Country of birth
Optional		Marital status	Occupation	**Please note if not born in NZ we require a copy of your passport and proof of visa status.**

Usual Residential Address	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
Contact Details	MobilePhone . Home Phone	Email Personal (see note below)	@
Emergency Contact /NOK	Name	Relationship	Mobile/Landline Contact

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

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 NZ*		
	☐ Yes, please request transfer of my records	☐ Casual	☐ No Previous Doctor
Signature	Previous Doctor and/or Practice Name	Address / Location	

Ethnicity Details
Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you

- ◯ NZ European
- ◯ NZ Maori
- ◯ Cook Is. Maori
- ◯ Samoan
- ◯ Tongan
- ◯ Niuean
- ◯ Chinese
- ◯ Sth Korean
- ◯ Filipino
- ◯ Indonesian
- ◯ Chinese Malay

Other eg. Indian, Sri Lanka, UK, Aust, USA, Canada, Niue, Iraq, Iran etc

Primary Language Spoken:
plus IWI if Maori:

Smokingstatus(ifover15) Neversmoked☐ Ex-smoker☐
Greater than 15mths ☐less than 12 mths☐Current smoker ☐
Would you like supporttoquit? Yes ☐Not right now☐

- ☐ I authorise **Glenfield Doctors** to contact me via textmessage
- ☐ I authorise **Glenfield Doctors** to contact me via aboveemail
- ☐ The nominated email address above is personal tome
- ☐ Alt email (eg. fam/work).....@.....

My Declaration of Entitlement And Eligibility

1) 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

2) I am eligible to enrol 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 for at least one year **AND** can also show that I am legally able to be in New Zealand for at least 2 years (previous permits included) Date of first Legal NZ entry.....	☐
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 criteria in clauses (a) to (f) above **OR** in the control 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's 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 ongoing provider for general practice / GP / primary health care services.

I understand that by enrolling with Glenfield Doctors on Chartwell I will be included in the enrolled population of Comprehensive Care PHO, and my name, address and other identification details will be included on the Practice, PHO 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 eg. ACC, Insurance Company requests, Ministry of Health, WINZetc.

I understand that if I visit another health care provider where I am not enrolled I most likely will 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 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.

Authority Details *(where 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)		