VICTORIA CLINIC
PATIENT ENROLMENT FORM

Each person 16 years or over to complete and sign own form

***Must be completed** NHI:

1. Personal Details:

Title: **Family Name:*** **First Name/s:***

Preferred Name: **Other name/s known by and/or Maiden name:**

Date of Birth:* **Gender:*** Please Tick ✓ **Account holder:** Please Tick ✓

M **F** **Y** **N**

2. Contact Details:

Physical Address:*

Unit/House No: **Street:** **Suburb:**

Town/City: **Postcode:**

Work Phone: **Home 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 ✓

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

Consent to use text messaging:

Yes / No Please Circle One

3. Ethnicity*:

WHICH ETHNIC GROUP DO YOU BELONG TO? (YOU MAY SELECT UP TO THREE ETHNICITIES):

NZ European/Pakeha	11		Tokelauan	35		Not Stated	99	
Maori (please state iwi)	21		African	53		Declined	98	
Samoan	31		Other Pacific	37		Latin American/Hispanic	52	
Cook Island Maori	32		Middle Eastern	51		Fijian	36	
Tongan	33		South East Asian	41		Other European	12	
Niuean	34		Other Asian	44				
Chinese	42							
Indian	43							
Other (please state)	54							

4. Residential Status:

Country of birth

If you are not born in NZ are you a NZ resident?	**Yes**		**No**		**Are you on a working Visa?**	**Yes**		**No**	
Are you a refugee:	**Yes**		**No**		Visa/Permit Sighted: (Office Use Only)	Yes		No	

SIGNED AUTHORITY:

I intend to use Victoria Clinic as my regular and on-going provider of General Practice// First level primary health care services

I am entitled to enrol because I am residing permanently in New Zealand[1] and meet one of the following eligibility criteria:

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.

MY AGREEMENT TO THE ENROLMENT PROCESS:

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

I choose to enrol with 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 this practice I will be enrolled with the Midlands Regional Health Network Charitable Trust, and my name address and other identification details will be included on both the Practice and the PHO Enrolment Register.

I understand that if I visit another 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 with the Midlands Regional Health Network Charitable Trust, and their contact details.

I have read and I agree with the Health Information Privacy Statement.

I agree to inform the practice of any changes in my eligibility.

	/ / Day Month Year
SIGNATURE*	**DATE***

OR signed by AUTHORITY[2]

Full Name of Authority:	Contact Phone Number:	Relationship:
Address:	Signature of Authority:	/ / Day Month Year
Detail the basis of authority (e.g. parent of a child under 16):		

[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.

General Information

4. Next of Kin/Emergency Contact Details:

Title: **Family Name :**

First Name/s: **Relationship:**

Physical Address:

Unit/House No: **Street:** **Suburb:**

Town/City: **Postcode:**

Day Phone: 0

Mobile Phone: 0

5. Employer:

Name:

Address:

Town/City: **Phone:**

Occupation:

6. Smoking Status:

☐ Never smoked ☐ In the past smoked daily for more than a year but no longer smoke ☐ Currently a smoker

7. Community Health Card Details:

Community Services Card No: 0 0 0 0 0

Expiry Date: / /

Sighted: (Office Use Only) Yes ☐ No ☐

High User Health Card No:

Expiry Date: / /

Sighted: (Office Use Only) Yes ☐ No ☐