SOUTH CITY HEALTH
91 Kahikatea Drive
Hamilton 3206
ENROLMENT FORM

thePHO
NEW ZEALAND PRIMARY HEALTH

File #

Shaded fields are compulsory	***Anyone over age of 16 years must complete their own enrolment form***	**NHI** *(Office use only)*

Legal Name	Title	Given Name	Other Given Name	Family Name
Other Name(s) (eg. maiden name)			**Preferred Name(s)**	
Birth Details		Day / Month / Year	Place of Birth	Country of birth
Sex (at birth)		☐ Male ☐ Female	**Gender** you would like to be identified as ☐ Male ☐ Female ☐ Gender Diverse (please state)	
Pronouns		☐ He ☐ She ☐ They ☐ Other Please state: _____ If not indicated will default to He / She as per gender		
Video Capabilities		Do you agree to phone / video consults where available (GP / Specialist) ☐ Yes ☐ No		
Usual Residential Address		House (or RAPID) Number & St	Suburb/Rural Location	Town / City & Postcode
Postal Address (if different from above)		House Number & St Name or PO Box	Suburb/Rural Delivery	Town / City & Postcode
Contact Details		Work Phone	Mobile Phone / Home Phone	Email Address
Occupation				
Employer Details		Company Name	Address	

Emergency Contact/NOK	Full Name	Relationship	Mobile (or other) Phone

Community Services Card	☐ Yes	☐ No	Expiry Day / Month / Year	Card Number
High User Health Card	☐ Yes	☐ No	Expiry Day / Month / Year	Card Number

Ethnicity Details

Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you

- ☐ 11 **New Zealand European**
- ☐ 12 **Other European**
- ☐ 21 **Maori** Iwi _____
- ☐ 31 **Samoan**
- ☐ 32 **Cook Island Maori**
- ☐ 33 **Tongan**
- ☐ 34 **Niuean**
- ☐ 41 **South East Asian**
- ☐ 42 **Chinese**
- ☐ 43 **Indian**
- ☐ 44 **Other Asian**
- ☐ **Other** (such as Dutch, Japanese, Tokelauan)

Please state:

Smoking is an important factor influencing health If you are aged 15 and over please tick the space that applies for you

- ☐ Currently smoke
- ☐ Recently quit
- ☐ Ex-smoker (over 1 year)
- ☐ Never smoked

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

NB Vaping is currently not classed as smoking

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, 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 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 **OR** 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, if requested, I can provide proof of my eligibility	☐	Evidence sighted (*Office use only*)

My agreement to the enrolment process

I intend to use this practice as my regular and on-going provider of general practice / GP / health care services.

I understand that by signing below I give permission for my records to be transferred from my previous practice to SOUTH CITY HEALTH

I have been given information about South City Health, including accounts, recalls, repeat prescriptions & appointment processes

I understand and agree that I am responsible for all costs related to the health services provided to me. Payment is due on the day of the consultation unless alternative arrangements have been agreed.

I understand that if I visit another health care provider where I am not enrolled, I may be charged a higher fee.

I understand that by enrolling with SOUTH CITY HEALTH I will be included in the enrolled population The PHO, and my name address and other identification details will be included on the Practice, PHO, and National Enrolment Service Registers.

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.

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.

NB. Parent or Caregiver to sign if you are under 16 years

Signatory Details	**Signature**	**Date signed**	☐ **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)		

File #

SOUTH CITY HEALTH
91 Kahikatea Drive
Hamilton 3206
Phone: 07 838 2323 Email: reception@sch.co.nz
Healthlink EDI: sthcityh

REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

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

I wish to register under:

☐	Dr Angela Hancock	NZMC 14735	☐	Dr Geraldine Tennent	NZMC 36402
☐	Dr Dasna Pallie	NZMC 46947	☐	Dr Damian Tomic	NZMC 19825
☐	Dr Aiswarya Swabu	NZMC 82170	☐		

In order to receive the best care possible, I agree to SOUTH CITY HEALTH obtaining my medical records from my previous doctor. I also understand that I will be removed from their practice register.

To: (previous Practice) **Phone:**

Address: **Email:**

Please transfer the medical records for the following people to SOUTH CITY HEALTH

Our practice is able to receive and would prefer electronic GP2GP notes transfer - Our EDI is: sthcityh

NHI	Family Name	Given Names	Date of Birth

Signed: _____ Date: _____