Patient Enrolment Form

University of Canterbury Health Centre
Private Bag 4800, Christchurch 8140
Ph +64 3 3642402 / Fax: +64 3 3642457

Transf of Notes: GP2GP **EDI: studcant**	**MC: 8543** **Dr Joan Allardyce**	**Student ID Number**	**NHI Number** *(office use only)*

Legal Name:	First Name	Middle Name	Surname	
Other Name(s) *e.g. maiden name, also known as*			Preferred name:	
Birth Details	Day / Month / Year of Birth	Place of Birth	Country of Birth	
Gender	☐ Male ☐ Female	If Gender Diverse, please state sexual identity (*circle*) **M F**	Occupation:	

Usual Residential Address	House (or RAPID) Number & Street Name	Suburb / Rural Location	Town / City & Postcode
Postal Address *(if different from above)*	House Number & Street Name or PO Box Number	Suburb / Rural Delivery	Town / City & Postcode

Contact Details	Mobile Phone	Home Phone	Email Address	
Emergency Contact	Name		Relationship	Contact Number:

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.*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Address / Location	

Which ethnic group to you belong to? *Mark the space(s) which apply to you:*	☐	NZ European	☐	Maori	**Iwi?**	
	☐	Samoan	☐	Cook Island Maori	☐	Tongan
	☐	Nuiean	☐	Chinese	☐	Indian
	☐ Other such as Dutch, Japanese, Tokelauan. Please state:					

Smoking Status	☐ Never smoked	☐ Ex-smoker	☐ Smoker *If yes, would you like support to quit Y / N*

National Patient Survey by MoH Patient Survey Contact Details *(this differs from the Campus Health Satisfaction Survey)*	From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous		
	☐ As provided (or)	Alternative mobile ph	Alternative Email Address
	☐ No, I do not wish to participate in the Patient Survey		

Signatory Details	Signature	Day / Month / Year

My declaration of entitlement and eligibility

I intend to use this practice as my regular and on-going of general practice / GP / health care services	☐
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 a 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 clause 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 Assistance 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 can 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 enrolling with UC Health Centre I will be included in the enrolled population of Christchurch PHO 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

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 agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

I understand that under the privacy laws my doctor may pass information to other health organisations to be used in a non-identifiable manner for health statistics. For funding purposes my doctor may be required to provide some identifiable information to other health organisations. I understand that my information may be used to include me in health screening programs. If I should need emergency or after hours care, relevant medical information in my file may be accessed by external authorized people. For details of practice policy regarding privacy and confidentiality, please check website or notices in clinic.

I have been given a copy of the Health Information Privacy Statement to read and am aware that I can contact the practice to clarify any issues that I do not fully understand. The information that 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 UC Health Centre may use the following methods to contact me: mobile/text/land-line/email/letter.

I authorise Health Centre personnel to access UoC Student Management System to confirm my demographic details and enrolment status.

I understand that I am only entitled to be enrolled at the UC Health Centre whilst enrolled as a current student at University of Canterbury.

Signatory Details	Signature	Day / Month / Year