EDI block GP2GP
Dr P Ruge NZMC 7284
Dr B Thomson NZMC 15350
Dr S Selvakumar NZMC 19262

Blockhouse Bay Medical Centre
503 Blockhouse Bay Road,
Blockhouse Bay 0600
ph 09 6279176 fax 09 627 2379

AUCKLAND PHO

PRACTICE ENROLMENT FORM

* = Mandatory Information – Practice Staff must ensure these fields are completed

Title	Mr Mrs Ms Miss Dr	**First Name(s)***		**NHI***	
				Family Name*	
Preferred Name				**Other Names Known By** (e.g. maiden name)	
Gender*	☐ Male ☐ Female			**Place / country of birth***	
Physical Address*	Street or Rapid (rural) number			**Date of Birth***	____/____/____ Day Month Year
	Suburb			**Community Services Card**	**YES / NO**
	City/Town	Postcode			**Card Number** **Expiry Date**
Postal Address				**High User Health Card**	**YES / NO**
					Card Number **Expiry Date**

My agreement to enrol: **I choose to enrol with Blockhouse Bay Medical Centre as my regular and ongoing provider of primary health care services. I understand** that by enrolling with this Medical Centre I will be enrolled with Auckland PHO, the Primary Health Organisation (PHO) this Medical Centre belongs to, 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 Medical Centre 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 PHO, 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.

SIGNATURE*	/ / Day Month Year

OR Signed by 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.

Full Name of Authority	Contact Phone Number	Relationship

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 ☐ No ☐ Not applicable ☐

Previous Doctor's Name:

Address / Location:

Please turn over

Which ethnic group do you belong to? Mark the space or spaces which apply to you *			
New Zealand European		Maori	
Samoan		Cook Islands Maori	
Tongan		Niuean	
Chinese		Indian	
Other, please state:			

Contact Details	Day Phone:	Night Phone:	Mobile Phone:	Email:
Next Of Kin	Name of person to contact:	Relationship:	Phone numbers:	

Eligibility for Subsidised Health Services

To be eligible for subsidised health services, you must meet the Ministry of Health's Eligibility Criteria. Please tick which of these Eligibility Criteria is applicable to you.

I intend to use Blockhouse Bay Medical Centre as my regular and on-going provider of primary health care services and **I am eligible to enrol** because **I live in New Zealand** and meet one of the following criteria:

- ☐ I am a New Zealand citizen
- ☐ I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)
- ☐ 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
- ☐ 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)
- ☐ I am an interim visa holder who was eligible immediately before my interim visa started
- ☐ 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
- ☐ I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one criterion above
- ☐ 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
- ☐ 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 am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme
- ☐ 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.

SIGNATURE*	/ / Day Month Year

OR Signed by 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.

Full Name of Authority	Contact Phone Number	Relationship

Smoking status please √

Current Smoker	Never Smoked	Past smoker less than one year	Past smoker more than one year