RICHMOND HEALTH CENTRE

Ph: 03-544-2255 Fax 03-544-1461

ENROLMENT FORM

40A Oxford Street
Richmond 7020
Nelson

Preferred Doctor		NHI (Office Use Only)

Legal Name (Title)	Given Name	Middle Name(s)	Family Name
Other Names	Preferred Name	Other Family Name (eg. Maiden Name	**Gender** ☐ Male ☐ Female ☐ Gender Diverse (please state)
Birth Details	Day / Month/ Year of Birth	Place of Birth	Country Of Birth
Contact Details	Mobile Phone	Home Phone	Email Address
Text Messaging	Do you consent to receive communication from this practice via text messaging?		Yes ☐ No ☐
Usual Residential Address	House (or RAPID) Number and Street Name	Suburb	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb	Town / City and Postcode

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

Your Employment Details	Employer	Occupation	or Retired ☐ or Child ☐
Emergency Contact	Name	Relationship to you	Mobile (or other) phone

Ethnicity Details
Which ethnic group(s) do you belong to?
Tick the space or spaces which apply to you

- ○ New Zealand European
- ○ Maori
- ○ Samoan
- ○ Cook Island Maori
- ○ Tongan
- ○ Niuean
- ○ Chinese
- ○ Indian
- ○ Other (such as Dutch, Japanese, Tokelauan). Please state

Smoking Status – Do you smoke tobacco?
(please tick one box)

Current Smoker ☐ Never Smoked ☐

Past Smoker

Given up more than 12 months ago ☐

Given up in the past 12 Months ☐

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	

Patient 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.*		
Patient Survey Contact Details	☐ As provided **(or)**	Alternative Mobile Phone	Alternative Email Address
	☐ No, I do not wish to participate in the Patient Survey		

Richmond Health Centre Ltd Terms of Trade: Payment is due at the time of your consultation unless prior arrangement has been made. If payment is not made on the day, the account is due within 7 days of invoice date. Overdue accounts will incur an account fee of $10.00. Accounts may be referred to a debt collection agency after 60 days. An additional fee and all collection costs will be added at time of referral. Our receptionists can assist you to set up regular automatic payments if this would be helpful. Patients with a poor credit history or repeat non attendances will be asked to pay for appointments at the time of booking. Cancellations may still incur a fee if insufficient notice is given.

My declaration of entitlement and eligibility

I intend to use this practice as my regular and on-going provider 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 I can provide proof of my eligibility** below)*	☐

If you are **not a New Zealand citizen** please tick which entitlement 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 and under 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 I am eligible and as required, I have provided proof of my eligibility

☐ Passport **OR** ☐ Birth Certificate + Photo ID

My agreement to the enrolment process

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

I understand that by enrolling with this practice I will be included in the enrolled population of the Primary Health Organisation (PHO) this practice is contracted to, 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 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 agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

Signatory Details	Signature	Date: 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)		

Office Use Only	Passport and/or Birth Cert ID…….. ID…… #……	Staff Member Initial