Dinsdale Medical Centre

Pinnacle Incorporated

ENROLMENT FORM

Office use only					
Received		**Checked**		**Entered**	
Initial	Date	Initial	Date	Initial	Date

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

PERSONAL DETAILS*:

Need to be legal details

Title*	Given Name*	Other Given Name*	Family name*

Other name:	Preferred name:
DATE OF BIRTH* * Day / Month / Year	* Place of Birth and * Country of birth
***Gender** you would like to be identified as ☐ Male ☐ Female ☐ Gender Diverse (please state)	**Sex*** (at birth) ☐ Male ☐ Female

CONTACT DETAILS*:

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
Work Phone	Mobile Phone*	Home Phone	Email Address*

ETHNICITY DETAILS*:

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

- ☐ **11 New Zealand European**
- ☐ **21 Māori Iwi _____**
- ☐ **31 Samoan**
- ☐ **32 Cook Island Māori**
- ☐ **Other ethnicity (please state) _____**
- ☐ **Tongan**
- ☐ **Niuean**
- ☐ **Chinese**
- ☐ **Indian**

RESIDENTIAL STATUS*:

- ☐ **NZ CITIZEN**
- ☐ **NZ RESIDENT OR PERMANENT RESIDENT**
- ☐ **WORK VISA**
- ☐ **REFUGEE VISA**
- ☐ **OTHER VISA (please state) _____**

NEXT OF KIN *:

Title*	Given Name*	Last name*
Contact details	Phone number*	Relationship*
Postal address	Street number and name *	Suburb/town/postcode*

COMMUNITY HEALTH DETAILS*:

Community card details	Card number*	Expired date (DD/MM/YYYY) *
High User Health card	Card number*	Expired date (DD/MM/YYYY) *

EMPLOYER*:

Name:	
Address:	
Ton/City:	Phone number:
Occupation:	

SMOKING INFORMATION*:

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

- ☐ Currently smoke
- ☐ Ex-smoker (over 1 year)
- ☐ Recently quit
- ☐ 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

* 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

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

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 this practice I will be included in the enrolled population of this practice's Primary Health Organisation (PHO) Midlands Regional Health Network Charitable Trust, 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 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.

Signatory Details	* **Signature**	* **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. Basis of authority (e.g., parent of a child under 16 years of age)

Authority Details *(Where signatory is not the enrolling person)*	Full Name	Relationship	Contact Phone

Dinsdale Medical Centre

Credit Policy & Terms and Conditions of our Medical Centre

NHI (*Office use only)*

Payment for your consultation is required on the day of service

- Payment is accepted by Cash, Eftpos, Visa or Mastercard
- Any services not paid for on the day will incur an administration fee of $15.00. You will have seven (7) working days to pay the account in full for the administration fee to be removed.

If you are unable to settle your account on the day of consultation, you must advise reception of this prior to your consultation.

1. Appointments are 15 minutes- if you require longer than this, please advise reception, additional charges will apply.
2. There is a minimum fee to see the nurse.
3. There is a charge for repeat prescriptions. These will only be issued for regular medications and you have been reviewed for by the doctor within the last 6 months. 48 Hours' notice is required for this service
4. Dinsdale Medical Centre uses the services of a debt collection agency. Any unpaid accounts plus the cost of recovering the unpaid account will be the responsibility of the patient.
5. Please advise us of any changes to your contact details or eligibility status
6. Dinsdale Medical Centre will not accept any verbal or physical abuse towards staff. Should an incident occur, it may affect your enrolment with our practice.

I acknowledge that I have read the above and agree with these terms and conditions.

Name :

Signed :

Date :

Phone: 07 847 8425 | Email: admin@dinsdalemed.co.nz| Address: 21 Whatawhata road, Dinsdale, Waikato 3204