15 PALMERS ROAD
PO BOX 88-071
CLENDON
AUCKLAND
2103
P: 09 267 4525
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Clendon Medical Centre

PATIENT ENROLMENT FORM

Please note all patients 16 years and over will need to sign their own form

TITLE	LAST NAME	GIVEN NAMES	DOB	GENDER

If the above patient is a child under 16: Mothers Name Maiden name

RESIDENTIAL ADDRESS	**POSTAL ADDRESS (If different from residential address)**
Home Phone	Mobile Phone
Work Phone	Email
EMERGENCY CONTACT	Name / Ph
Address	Relationship
WORK DETAILS (this info will only be used if you have an accident)	Company Name
Occupation	Address
Are you a NZ Resident/Citizen/Work Permit:	Do you have a Community Services Card/Super Gold Card:
Country of Birth	If you were born outside of NZ what year did you enter NZ:

ETHNICITY

☐ NZ European/Pakeha	☐ Tongan	☐ Chinese	☐ Middle Eastern
☐ Other European	☐ Niuean	☐ Indian	☐ Latin American
☐ NZ Maori	☐ Tokelauan	☐ South East Asian	☐ African
Iwi: _____	☐ Fijian	☐ Cook Island Maori	☐ Other
☐ Samoan	☐ Other Pacific	☐ Other Asian	☐ Not Stated

I wish to enrol with Clendon Medical Centre and I understand that:

- This practice is a member of a Primary Health Organisation (PHO) and I have been informed of the implications of enrolment with this PHO. I cannot enrol with more than one practice at the same time.
- The practice is funding basis on its enrolled register and information on this form will be sent to the Health Funding Organisation.
- I agree to the practice sharing my health information with other health providers involved in my healthcare.
- My information may be used for practice quality/audit activities and to being included in the practice screening and recall programmes.
- All accounts are payable on the same day services are provided. If account is not paid after 3 months, it will then be referred to a debt collection agency and that I will be liable for all the additional cost incurred in attempting to recover any debts including legal fees or charges levied by the collectors.

I authorize the transfer of my medical records from my previous doctor

Practice/Doctor Name of Previous Doctor

Address of Previous Doctor/Practice

Please send notes via GP2GP – EDI: clndnmc

- ☐ Dr Richard Kenner MC #: 11711
- ☐ Dr Richard Ruddell MC #: 13809
- ☐ Dr Peter Didsbury MC#: 11607
- ☐ Dr Jeremy West MC#: 11708
- ☐ Dr Daya Mudannayake MC#: 7226

I understand that my name will be removed from the register of my previous general practice.
I have read this document and understand all the comments and agree that I am now enrolled patient of Clendon Medical Centre

Signature:	**Date:**	**Office Use Only** **NHI:**

****Important: All patients who were not born in NZ are requested to provide their passport at the time of enrolment to assist with obtaining NHI numbers and Eligibility****