

15 PALMERS ROAD
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CLENDON
AUCKLAND
2103
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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				
<input type="checkbox"/> NZ European/Pakeha <input type="checkbox"/> Tongan <input type="checkbox"/> Chinese <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Other European <input type="checkbox"/> Niuean <input type="checkbox"/> Indian <input type="checkbox"/> Latin American <input type="checkbox"/> NZ Maori <input type="checkbox"/> Tokelauan <input type="checkbox"/> South East Asian <input type="checkbox"/> African Iwi: _____ <input type="checkbox"/> Fijian <input type="checkbox"/> Cook Island Maori <input type="checkbox"/> Other <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific <input type="checkbox"/> Other Asian <input type="checkbox"/> Not Stated				
I wish to enrol with Clendon Medical Centre and I understand that:		I authorize the transfer of my medical records from my previous doctor		
<ul style="list-style-type: none"> 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. 		Practice/Doctor Name of Previous Doctor Address of Previous Doctor/Practice Please send notes via GP2GP – EDI: clndnmc <input type="checkbox"/> Dr Richard Kenner MC #: 11711 <input type="checkbox"/> Dr Richard Ruddell MC #: 13809 <input type="checkbox"/> Dr Peter Didsbury MC#: 11607 <input type="checkbox"/> Dr Jeremy West MC#: 11708 <input type="checkbox"/> Dr Daya Mudannayake MC#: 7226		
<p align="center">I understand that my name will be removed from the register of my previous general practice.</p> <p align="center">I have read this document and understand all the comments and agree that I am now enrolled patient of</p> <p align="center">Clendon Medical Centre</p>				
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****