ROYAL HEIGHTS MEDICAL CENTRE

38 Royal Road, Royal Heights, Massey, Auckland 0614
Telephone: (09)833-7347, Fax: (09)833-6177, EDI royalhmc
email: royalhgtsmedctre@gmail.com

Dr Joanna Lapish NZMC 29940 ☐
Dr Dragica Katic NZMC 22478 ☐
Dr Jing Li NZMC 37705 ☐
Dr Gabrielle Farley NZMC 79162 ☐
Dr Kee Ping Lim NZMC 64583 ☐

ENROLMENT FORM		**NHI***	
Title: Mr Mrs Ms Miss Dr Mast	**Family* Name**	**First Name***	
Preferred Name		**Other Given Names***	
Gender*	☐ **Male** ☐ **Female** ☐ **Gender diverse (please state)**	**Place of birth***	
Usual Residential Address*	House (or RAPID)Number and Street Name Suburb City / Town / Postcode	**Country of birth***	
		Date of Birth*	_____/_____/_____ Day Month Year
		Community Services Card	**YES** ☐ **NO** ☐ **Card Number:**
			Expiry Date:
Postal Address		**Occupation**	
Contact Details	**Day Phone:** (work) **Night Phone:** (Home) **Mobile Phone:**	**Email Address**	**Do you agree to receive text messages?** **Yes** ☐ **No** ☐
Emergency Contact	**Name of person to contact:**	**Relationship**	**Phone number**

Which ethnic group do you belong to? **Mark the space or spaces which apply to you***	
New Zealand European	
Māori Iwi / Hapu:	
Samoan	
Cook Islands Maori	
Tongan	
Niuean	
Chinese	
Indian	

Smoking History		
		Never smoked
		Smoker
		Ex Smoker(more than 12months)
		Ex Smoker(less than 12months)

Smoking is bad for you. Would you like advice on how to quit?
Yes ☐ No ☐

Transfer of Records: preferably GP2GP

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 ☐
Doctor's Name:

Other: (please state)		**Address / Location:** **Phone:** **Fax:** **Email:**

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 with the Primary Health Organisation (PHO) this practice belongs 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 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.

Authority Details	Full Name	Relationship	Contact Phone

(where signatory is not the enrolling person)	Basis of authority (e.g. parent of a child under 16 years of age)