ENROLMENT FORM
Dodson Medical Centre

Address 4 Dodson Avenue, Milford, 0620
P: 486 5482
F: 489 5055
EDI: dodsonhc

CHART #:

NB: REMEMBER TO ATTACH ID

Office Use

Signed	☐	ID scan	☐
Smoking	☐	NP/V Alert	☐
NES/NHI	☐	Connect	☐
Enrolled	☐	Notes Rq	☐

Completed By _____

Chris Maud	**9091** ☐	**Luke Ivancevic**	**23351** ☐	**Antje Bongartz**	**60776** ☐	**NHI** ***(Office use only)***
Sue Loughlin	**17533** ☐	**Paul Stoddart**	**13986** ☐			

Legal Name	(Title)	Given Name	Middle Name(s)	Family Name
Other Name(s)		Preferred Name	Maiden Name	Other Name
Birth Details		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender		☐ Male ☐ Female	☐ Gender diverse (please state)	
Optional		Marital status		Occupation

Usual Residential Address	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode
Contact Details	Mobile Phone / Home Phone	Email Address	
Emergency Contact /NOK	Name	Relationship	Mobile (or other) Phone

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

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, as I am only able to be enrolled at 1 practice at a time in NZ*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Address / Location	

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

Primary Language Spoken:

IWI

Smoking status (Required if over 15)
Never smoked ☐ Current smoker ☐
Ex-smoker ☐ Greater than 15months ☐ Less than 12 months ☐
Would you like support to quit? Yes ☐ No ☐

☐ I authorise Dodson Medical to contact me via text message
☐ I authorise Dodson Medical to contact me via email (non-secure)
Do you have Medical Insurance; Yes ☐ No ☐
If yes which scheme? Member #:

* 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*)** ☐
Eligibility proof attached (NZ birth cert/NZ Passport /other passport & relevant visas		☐

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 **DODSON MEDICAL** I will be included in the enrolled population of Comprehensive Care 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 *(where signatory is not the enrolling person)*	Full Name	Relationship	Contact Phone
Authority Details	Basis of authority (e.g. parent of a child under 16 years of age)		

Dodson Medical Centre

ConnectMed – Patient Portal Registration Form (OVER 16 YEAR OLDS ONLY)

Please complete this form and supply one form of photo ID to register for the ConnectMed patient portal.

Each person that uses the portal must have their own unique email address.

Full Name: _____

Date of Birth: _____

Email Address: _____

Cell Phone: _____

DECLARATION

I have read and understand the attached information.

I will use the Patient Portal to check lab results, and action the doctor's recommendations.

I am aware that for acute serious problems I will call the surgery 4865482 or 111 in an emergency

***Previously enrolled with ConnectMed?** **YES** ☐ **NO** ☐

***Previously used ConnectMed with another practice?** **YES** ☐ **NO** ☐

Signature**:** _____

Date: _____

Practice use only

Patient NHI: _____

Photo ID: DRIVERS LICENCE/PASSPORT Number: _____

Patient Registered on ConnectMed (level2) _____

Alert Set: _____

Staff Member: _____

Date Completed: _____