THE GOOD DOCTOR
COMMERCE STREET MEDICAL CENTRE

ENROLMENT FORM

The Good Doctor
Commerce Street Medical Centre
G02/124 Commerce Street
Frankton, Hamilton
Phone: 07 4444 181
www.gooddoctor.co.nz

EDI/GP2GP: commerce

OFFICE USE ONLY:
- ☐ID Scanned
- ☐Eligibility Scanned
- ☐NOK Checked
- ☐Registered on Medtech
- ☐GP2GP Requested

Staff Initials:

Fields marked with an * are compulsory

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Name	(Title)	*Given Name	*Other Given Name(s)	*Family Name
Birth Details		*Day / Month / Year of Birth	*Place of Birth	*Country of birth
Gender (please tick)		☐ *Male ☐ *Female ☐ *Gender diverse (please state)		***NHI (*Office use only*)**

Residential Address	*House Number and Street Name	*Suburb	*Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb	Town / City and Postcode

Contact Details	*Mobile Phone	Home Phone	*Email Address
Emergency Contact Person	*Name	*Relationship	*Mobile (or other) Phone

Occupation	Company Name	Occupation
	Company Address	Work Phone

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***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:***

Iwi:

Hapu:

Community Services Card Number	*Expiry Date*
High User Health Card Number	*Expiry Date*

*** Smoking status (if over 15)**

☐ Never smoked ☐ Current smoker
☐ Ex-smoker
☐ Greater than 15 months
☐ Less than 12 months

If you are a current smoker or have recently quit, we would like to help you stop to improve your health. Would you like help to stop/stay an ex-smoker?

☐ Yes ☐ No

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***Transfer of Records**	I agree to The Good Doctor Commerce Street Medical Centre obtaining my records from my previous doctor, which will mean I will be removed from their practice register.	
☐ Yes, please request transfer	☐Not applicable	* Signature
* Previous Doctor and/or Practice Name and Address		

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***My declaration of entitlement**

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

5 *My declaration of eligibility

I am ELIGIBILE to enrol because:

a	**I am a New Zealand citizen (***If yes, tick box,* **skip sections b-j, and proceed to Section 6** *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	☐

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*I confirm that I can provide proof of my eligibility	☐	
My work/student/visitor/other visa is valid for a period of	Year(s) Valid:	Expiry Date:

7 *My agreement to the enrolment process

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 **The Good Doctor Commerce Street Medical Centre** I will be included in the enrolled population of National Hauora Coalition PHO, and my name address and other identification details will be included on the Practice, PHO, and National Enrolment Service Registers. **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 understand that if I visit another health care provider where I am not enrolled, I may be charged a higher fee.

I agree to inform the Practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

I consent to the Practice sending text messages and emails for the purpose of recalls, surveys, updating my details and for communication related to healthcare. I understand that I can opt out of this by filling out a form which is available at the reception.

I consent to the Practice using transcription software and AI tools in compliance with NZ law to assist with my care. I understand that I can opt out of this by filling out a form which is available at the reception.

I agree to the fees and service charges of the Practice, which I have had the time to review before signing up. These prices are also available on the Practice's website as well as at the reception.

I understand the prices might be updated in the future and I take responsibility to check the prices prior to the appointment.

I understand that the fees are to be paid prior to the appointment. If not paid in full, the appointment will be rescheduled and I will be charged for the original appointment as well as the new rescheduled appointment.

I understand any delayed payment will also incur an admin fee as per the Practice policy.

I agree to adhere to Practice policies regarding late show, DNA (Did Not Attend) and cancellation, and accept that I will be charged in compliance with the Practice policies.

Signatory Details	*Signature. Parent or Caregiver to sign if under 16 years.	*Date	☐ Self-Signing	☐ Authority

Authority Details *(Where signatory is not the enrolling person)*	Full Name	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age) ***An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.***		