

WELCOME TO ANNE STREET MEDICAL CENTRE

29 Anne Street, Devonport, Auckland
Ph 445-3483 fax 445-0559

Registration / Enrolment form

Last / Family Name: _____ **Title:** (Mr, Mrs, Ms, Miss, etc): _____

First Names: _____ **Preferred name:** _____

Date of Birth: _____

Does any member of your family already attend our practice and, if so, their names? _____

Address: _____

Phone: _____ (work/daytime) _____ (home) _____ (mobile)

E-Mail: _____

Next of Kin / Emergency Contact Person: _____

Relationship – spouse – parent – grandparent – neighbour Phone no.: _____

Ethnicity (circle one) – Pakeha / European NZ Maori Samoan Tongan Asian Indian
Other European Other Pacific or Other _____

Community Services or High User Card: Yes / No (If Yes, please show reception)

Are you a NZ Resident? yes / no (we may ask you to show us proof of eligibility eg. work permit, passport)

Are you joining this practice? Yes / No

ENROLMENT

I wish to enrol with this medical centre as my preferred provider for general practice services.

- I understand that I cannot enrol with more than one practice at the same time, and that my previous doctor will be advised that I no longer wish to be enrolled with him / her.
- You are my preferred provider of General Practice Services. I give permission for my name (or a child under the age of 16 years who is under my custody) to be added to your Enrolment Register.
- I understand the reasons and implications of being enrolled with you as outlined in the information available for patients.
- By enrolling with this practice, I will be part of your patient population for funding purposes and the Ministry of Health and ProCare Network North may access this register for audit purposes. I understand that this practice will be advised if I use subsidised services of another practice or primary care facility.
- A copy of ProCare Network North's privacy policy that describes the information collected by this practice and how it will be used is available in the practice for my use and to take away. I give permission for my health and medical records to be confidentially used as described in the policy.

I authorise this practice to obtain my previous general practice records to assist in my further care and treatment. Yes / No (if Yes, this form will be sent to your previous doctor, only if in NZ)

My previous Doctor was _____
Address: _____

Notes can be forwarded by EDI to "annest"

I agree to pay for all consultations at the time of the appointment, unless some other arrangement is made in advance. I understand that if I am given an account, and if this remains unpaid after 3 months, then it may be placed in the hands of a debt collection agency and that all costs related to debt collection will be passed on to myself.

I have read this document and understand all the comments and agree that I am now an enrolled patient for Anne Street Medical Centre. I agree to the above terms.

(signature) _____ Date: _____