

# ProCare Network North

## PHO ENROLMENT FORM PASIFIKA INTEGRATED FAMILY MEDICAL CENTRE LTD

Each adult 16 or over to complete & sign own form



### PERSONAL DETAILS

Family Name: \_\_\_\_\_ First Names: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male/Female (please circle) Ethnicity \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Occupation & Employers Details \_\_\_\_\_

Community Services Card, Number 00000 \_\_\_\_\_ Higher User Card, Number \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Address/Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

<b>Country of Birth</b>	
If you were not born in New Zealand, <b>are you a New Zealand resident</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

- I understand the reasons and implications of being enrolled with you as outlined in the information available for patients
- You are my preferred provider of general practices services. I give my permission for my name to be added to your Enrolment Register
- The ProCare Network North's Information Privacy Statement that describes the information collected by this practice and how it will be used is printed in an enrolment brochure for my use and to take away. I give permission for my health and medical records to be confidentially used as described in this statement
- 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.
- 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.
- I understand that this practice is entitled to charge a fee for the health services it provides and that I agree to pay such costs according to the policy of the practice including any additional costs associated with the collection of overdue or unpaid accounts

I have read this document and understand all the comments and agree that I am now an enrolled patient of this practice.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Reason/s for Enrolment (tick box to indicate)

- New Patient (no previous GP)  New to area and NZ  
 Transfer from another GP (see attached transfer request form)

I wish to enrol with Pasifika Integrated Family Medical Centre Yes/No (please circle)

### TRANSFER REQUEST from Previous GP

I wish to transfer all my medical records from GP/Clinic name: \_\_\_\_\_

Please release my medical records to Pasifika Integrated Family Medical Centre Ltd, 1 Nile Road, Milford, North Shore, Ph 09 4100275, Fax 09 4100282, EDI: pifmcltd

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please turn over to enrol other members of my family under the age of 16

**Please note: UNPAID ACCOUNTS WILL INCUR COLLECTION COSTS**

**I also wish to enroll the following people in my custody who are all under the age of 16 years:**

First Name(s) \_\_\_\_\_ Male/Female (*please circle*)

Family Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Ethnicity \_\_\_\_\_

Your relationship (Parent/Guardian/Caregiver, etc)

First Name(s) \_\_\_\_\_ Male/Female (*please circle*)

Family Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Ethnicity \_\_\_\_\_

Your relationship (Parent/Guardian/Caregiver, etc)

First Name(s) \_\_\_\_\_ Male/Female (*please circle*)

Family Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Ethnicity \_\_\_\_\_

Your relationship (Parent/Guardian/Caregiver, etc)

First Name(s) \_\_\_\_\_ Male/Female (*please circle*)

Family Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Ethnicity \_\_\_\_\_

Your relationship (Parent/Guardian/Caregiver, etc)

First Name(s) \_\_\_\_\_ Male/Female (*please circle*)

Family Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Ethnicity \_\_\_\_\_

Your relationship (Parent/Guardian/Caregiver, etc)