

Hobsonville point Medical centre

3a/160 Hobsonville point Road ,Hobsonville,Auckland

Phone -092220381/Fax-092220383

EDI-hobhobmc

Enrolment Registration / Request for Medical Notes

Please Circle: Mr Mrs Miss Ms Gender: Male/Female NZ Citizen/Resident: Yes/No

Family Name.....First Name.....Other Names.....

Home Address.....Suburb.....City.....

Phone.....Mobile.....Date of Birth.....NHI.....

Occupation.....Email.....

Patient/Account Holder Details

Ethnicity:

NZ Maori	Samoan	Niuean	Tongan
NZ European	Indian	Chinese	Other Asian
Other European	African	Other Pacific	Sri Lankan

Other – Please Specify.....

CSC No.....Expiry Date.....Winz No.....

Next of Kin.....Phone.....

Address.....Relationship.....

Dependants (Children under 16years of age)

Family Name.....First Name.....DOB.....M/F

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I understand by signing this enrolment form:I have nominated Hobsonville point medical centre as my/our Primary Care Provider and I intend to use this Practice as my/our usual and ongoing provider of General Practice/GP/First Level Primary Health Care Services

This Practice is a member of the National Hauora Coalition Primary Health Organisation (PHO). I/we can un-enrol at any time. For funding and planning purposes my/our enrolment/register information will be disclosed to the PHO, WHD and the Ministry of Health.

I am eligible to enrol because I meet one of the following criteria:-

- I am a NZ citizen AND am currently residing permanently in NZ OR
- I hold a residence permit AND have been in NZ for at least 2years, or hold a current returning resident visa
- I am an Australian citizen able to show my total stay in NZ is or will be for at least 2years OR
- I hold a work permit or am an international student able to show I can be in NZ for at least 2years OR
- I am a Refugee or in the process of applying for Refugee status
- I confirm that, if requested, I can provide proof of my eligibility

By signing this form I authorise the TRANSFER of my/our medical records to the Hobsonville point_Health Centre Ltd.

Previous GP Name.....Address.....Phone.....

Patient's Signature.....Date.....

OFFICE USE ONLY: Reception to complete before scanning into MedTech32

We Do GP to GP transfer-Name OF GP Registration Number (NMC).....

Transfer Request Date Faxed.....GP Fax No.....Date.....