6 Avalon Drive
Nawton HAMILTON
P: 078460082 F: 078460085
E: enquiries@avalonhealth.co.nz
W: avalonmedical.co.nz
AVALON MEDICAL

National Hauora Coalition

Avalon Medical
ENROLMENT FORM

Office Use Only:
Date Form Signed: _____ Staff: _____

Legal Name*	(Title)	**Given Name**	**Other Given Name(s)**	**Family**
Other Name(s) eg. maiden name) Please tick the name you prefer to be known as				
Birth Details*		**Day/Month/Year of Birth***	**Place of Birth***	**Country of Birth***
Gender*	☐ **Male**	☐ **Female**	☐ **Gender diverse (please state)**	**NHI No:**
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**	I agree to receiving Txt messages Yes ☐ No ☐ Email Address
Emergency Contact (EC) NOK Contact (if different from EC)		Name Name		Relationship Relationship
				Mobile (or other) Phone 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

Ethnicity Details

Which ethnic group do you belong to? (Tick box/es that apply to you:

- ☐ New Zealand European
- ☐ NZ Maori
- ☐ Samoan
- ☐ Cook Island Maori
- ☐ Tongan
- ☐ Niuean
- ☐ Asian
- ☐ Indian
- ☐ Other. Please state: _____

Iwi: _____ (optional)

Smoking Status

Smoking Status	Smoker ☐	Never Smoked ☐	Ex Smoker ☐ No. years since quit _____

Smoking is bad for your health, ***it can affect your health outcomes and slow recovery from infection or disease.***

Please see your doctor if you would like to quit. We are here to help

Employment Details

Name

Address

Occupation:

Type of Work:
(Please circle) Sedentary Light Medium Heavy Very Heavy

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. **PLEASE COMPLETE ADDITIONAL REQUEST TO TRANSFER FORM**

☐ Yes, please request transfer of my records ☐ Not applicable

OFFICE USE ONLY: Patient Identity	**Type of document** **Last 4 digits (if applicable) i.e. PP…2365**	**Expiry date for Passports** **Start date – End date for Visa** **Does this meet 2 year visa criteria Yes No**

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)

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 **Avalon Medical,** I will be included in the enrolled population of this practice's Primary Health Organisation (PHO) National Hauora Coalition (NHC) 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 2020.

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.

If you are female aged between 45-65 years, you may be eligible to enrol in the **BreastScreen Aotearoa** free breast screening programme. Do you give your consent for **Avalon Medical** to enrol you if and when you are eligible **YES NO**

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 Number**	
	Basis of authority (e.g. Parent of a child under 16 years of age)			

Form Version	NHC Version 12 Dated: 04 October 2023

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REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

Each person 16 years or over to complete and sign their own form

In order to receive the best care possible, I agree to Avalon Medical, HAMILTON obtaining my medical records from my previous doctor.

I also understand that I will be removed from my previous doctor's practice register.

To: _____ **[name of previous doctor]**

Address: _____ **[address of previous medical centre]**

NB: This practice uses GP2GP to transfer patient records

Requesting Provider details:

☐ **First Name:** **Avalon** **Last Name:** **Medical** **NZMC:** **19039**

Practice Healthlink code / EDI: **tuhikara**

Please transfer the medical records for the following people to Avalon Medical

Family Name	Given Name	DOB or NHI

Signed: _____ **Name:** _____ **Date:** _____

Signed: _____ **Name:** _____ **Date:** _____