

**WEBSITE**

**CITYMED DOCTORS LTD**

(8 Albert St, Auckland 1010 – Ph: 09 377 5525 – Fax: 09 379 3793 – EDI: victormc)

**PATIENT REGISTRATION AND ENROLMENT FORM**

**REGISTRATION**

Last/Family Name:..... First/Given Names: .....

Mr/Mrs/Ms (please circle) Preferred First Name:.....

Date of Birth:..... Maiden name if married:.....

Male  Female  Occupation:.....

Street Address:.....

Postal Address (if different from above):.....

Work/Daytime Number:..... Home Number:.....

Mobile Number:..... Do you consent to receive text messages on this number: Yes/No

Email:..... Do you consent to receive e-mail from CityMed: Yes/No

**Next of kin/emergency contact person**

Name:..... Phone:.....

Relationship – e.g. spouse, parent, grandparent, neighbour, etc.....

New Zealand Citizen/Permanent Resident Yes/No **(NB: proof maybe required)**

Work/Student Visa (please circle) 1yr/2yrs (please circle) **(NB: visa will need to be sighted)**

Community Service/High User Health Card Yes/No (if yes please show reception)

**Ethnicity** – (circle one) –NZ European | Maori: Iwi. \_\_\_\_\_

Chinese | South East Asian | Other Asian | Middle Eastern | African | Latin American | Indian | Other European

Fijian | Samoan Tongan | Niuean | Tokelauan | Cook Island Maori | Other Pacific | Other \_\_\_\_\_

**Payment is expected at each visit. If you are given an account please note that a \$5 administration fee will incur after 30 days. If your account remains unpaid after 90 days then it will be referred to a debt collector, which will result in further costs for you.**

Signature:.....Print Name.....Date:.....

**ENROLMENT**

I authorise this practice to obtain my previous medical records to assist in my further care and treatment.

Yes  No  (If yes, this form will be sent to your previous doctor)

**I understand that:**

- This provider is a member of a Primary Health Organisation (PHO) and I have been informed of the implications of enrolment with this PHO.
- I cannot enrol with more than one practice at the same time.
- This practice is funded on the basis of its enrolled register and information on this form will be sent to the Health Funding Organisation.
- I agree to the practice sharing my health information with other health providers involved in my healthcare.
- My information may be used for practice screening & recall programmes, and practice quality activities and audit.
- I have read this document and understand and agree that I am now an enrolled patient of this practice.

I have been given and read the Rules of Enrolment and Privacy Health Information handout.

I understand that my name will be removed from the register of my previous general practice.

My previous doctor was:.....

My previous doctor’s address:.....

Signature: ..... Print Name..... Date:.....