

CITYMED WEBSITE REGISTRATION/ENROLMENT FORM

REGISTRATION

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

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

Street Address:.....

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

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

Mobile Number:..... Email:.....

Date of Birth:..... Male Female

Maiden name if married:.....

Ethnicity – (circle one) – NZ European-Maori-Chinese-South East Asian-Other Asian-Middle Eastern- Fijian- Samoan-Tongan- Niuean-Tokelauan-Cook Island Maori- Other Pacific Islander-African-Latin American/Hispanic-Indian-Other European

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

New Zealand Citizen/Permanent Resident No / Yes

Work/Student Visa (please circle) 1yr/2yrs (please circle)

CityMed Drs Ltd
8 Lower Albert Street
Central Auckland

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.

I agree to the above terms: Signature:..... Date:.....

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 The Network 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 The Network’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 this policy.

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)

My previous doctor was:.....

My previous doctor’s address:.....

Next of kin/emergency contact person

Name:.....

Phone or address:.....

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

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

Signature: Date:.....