BAKERFIELD MEDICAL & URGENT CARE

PATIENT DETAILS

Bakerfield Medical & Urgent Care
16a Bakerfield Place, Manukau City 2104
Phone: 09 263 7770 Fax: 09 2637769
EDI: manuakae

PERSONAL DETAILS		
Surname	**Legal first name**	
Preferred first name	**Other known names**	**NHI number**
Date of birth _____ / _____ / _____ Day Month Year	**Gender** Male / Female	
Country of birth	**Residency Status**	
Physical address		
Postal address (if different from above)		
Home phone	**Mobile phone**	
Community Services Card Number:	Expiry date:	
High User Card Number:	Expiry date:	
Next of Kin Name: Phone:	Relationship:	

Ethnicity

NZ European	☐	Fijian/Indian	☐	Chinese	☐
Maori	☐	Niuean	☐	Indian	☐
Samoan	☐	Other Pacific Island	☐	Other Asian	☐
Cook Island Maori	☐	Middle Eastern	☐	African	☐
Tongan	☐	Latin American	☐	Other European	☐
Other *(please specify)*	☐	_____			

EMPLOYMENT DETAILS	
Company Name:	**Occupation:**
Company Address:	**Work Phone number:**
DO YOU WISH TO HAVE YOUR NOTES SENT TO YOU OWN DOCTOR? IF YES PLEASE GIVE DETAILS OF YOUR OWN DOCTOR TO THE RECEPTIONIST.	**YES / NO**

REQUEST TO ENROL
Do you wish to enrol at this clinic? YES / NO **IF YES, PLEASE ASK RECEPTIONIST FOR AN ENROLMENT FORM TO ENJOY BETTER FEES AND SERVICE IN OUR CLINIC. PLEASE HAND THIS FORM BACK TO RECEPTIONIST.**

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ENROLMENT ELIGIBILITY

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

- ☐ I am a New Zealand citizen AND I am currently residing in New Zealand
- ☐ I hold a residence permit AND I have been in New Zealand for at least 2 years, or hold a current returning residents visa
- ☐ I am an Australian citizen able to show that my total stay in New Zealand is or will be for at least 2 years
- ☐ I am a work permit holder or an international student able to show that I am able to be in New Zealand for at least 2 years
- ☐ 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.

AGREEMENT TO ENROL

I choose to enrol with this practice as my regular and on going provider of general practice / GP / First Level primary health care services.

I understand that by enrolling with this practice I will be enrolled with the Primary Health Organisation (PHO) this practice belongs to, and my name, address and other identification details will be included on both the Practice and the PHO Enrolment Register.

I understand that if I visit another provider where I am not enrolled I may be charged a higher fee.

I understand that if I enrol at another clinic I will forfeit my enrolment at this clinic.

I have been given information about the benefits and implications of enrolment with the PHO, and their contact details.

I have been given access to the Health Information Privacy Statement

I agree to inform the practice of any changes in my eligibility.

I declare that all of the information I have provided is accurate and correct.

SIGNATURE

NB: Parent or caregiver to sign if you are under 16 years

Signature	**Date**

SIGNATURE AUTHORITY

If signing on behalf of somebody else, please complete following details.
By signing you confirm that you have the authority to sign on behalf of the patient.

Full name of authority	**Relationship to patient**
Address	**Phone number**

Basis of authority

- Parent of a child under 16 years □
- Guardian/Caregiver □
- Other *(please specify)* □

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