

Unit C12, Waimauku Shopping Centre, 5-19 Factory Road, Waimauku  
 Phone: 09 411 5222 Fax: 09 411 5276 EDI: silverfe website: www.silverfernmedical.co.nz

## PATIENT ENROLMENT FORM – Please complete and fax or scan/email to [reception@silverfernmedical.co.nz](mailto:reception@silverfernmedical.co.nz), please note that your signature is required on page 2

### 1. Each person aged 16 and over needs to sign their own form

Family Name	Given Name	Preferred Name	Date of Birth	Sex	Ethnicity
1.					
2.					
3.					
4.					

### 2. Marital Status: (circle one)    Married                      Partnered                      Single                      Divorced                      Widowed

### 3. Ethnicity

Which ethnic group do you identify with? Please write code number in the ethnicity column above for each person being enrolled. You may indicate more than one ethnic group. However, the first code number used will be classed as your primary ethnicity.

- |                        |                             |              |               |                          |
|------------------------|-----------------------------|--------------|---------------|--------------------------|
| 11 NZ European         | 12 Other European           | 21 Maori     | 31 Samoan     | 32 Cook Island Maori     |
| 33 Tongan              | 34 Niuean                   | 35 Tokelauan | 36 Fijian     | 37 Other Pacific Islands |
| 40 Asian not defined   | 41 South East Asian         | 42 Chinese   | 43 Indian     | 44 Other Asian           |
| 51 Middle Eastern      | 52 Latin American/ Hispanic |              | 53 African    |                          |
| 54 Other: Please state |                             |              | 99 Not stated |                          |

### 4. Contact Details

Street Address			
Suburb/Town			
City		Post Code	
Phone (work)		Phone (home)	
Occupation		Phone (mobile)	
Email			

### 5. Next of Kin/Emergency contact details

Name			Relationship		
Street Address					
Phone (home)		Phone (mobile)		Phone (work)	

### 6. Community Services Card and or High User Health Card – if you have a CSC and or HUHC please show this to the receptionist.

### 7. Are you a New Zealand Citizen?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
If no: Are you a permanent resident in NZ?	<input type="checkbox"/>	No	<input type="checkbox"/>	<b>If no: Passport and visa to be sighted</b>
Work permit Status of at least 2 years	<input type="checkbox"/>	No	<input type="checkbox"/>	
Refugee Status	<input type="checkbox"/>	No	<input type="checkbox"/>	

### 8. Smoking is an important factor influencing health. Please tick the space that applies to all those aged 15 and over

Patient (as per 1 above)	1	2	3	4
I have never smoked				
In the past I have smoked daily for more than a year, but no longer smoke				
I am currently a smoker				

**N.B. Please sign the form overleaf in order to have your records transferred and be eligible for subsidised appointments.**



**SILVER  
FERN  
MEDICAL  
CENTRE**

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**Please enrol me (and/or my child/children under 16 years) on your practice register**

**By enrolling with Silver Fern Medical Centre I confirm I understand the following:**

- Silver Fern Medical will become my preferred provider of general practice services.
- While I am enrolled with Silver Fern Medical for funding purposes, the Ministry of Health will inform the practice and Harbour Health of the date/s on which I visit any other general practice.
- Routine practice services include recalls for preventive healthcare but I can request not to be recalled.
- I am also enrolling with Harbour Health and have been given information on what enrolment means.
- I will be part of Silver Fern Medical patient population for funding purposes and the Ministry of Health and Harbour Health may access this register for population health and funding purposes.
- The privacy of my personal and health information will be protected as per the Health Information Privacy Code 1994, and I have been provided with information on what this means.
- A National Health Index (NHI) number will be attached to my records.
- I consent to Silver Fern Medical sharing information with their own pharmacy in order to optimise my care.

**Request the Transfer of my/our Medical Records**

**I understand that I will be removed from the register of my previous General Practice and I authorise the transfer of my records (and/or my child/children under 16 years) Yes/No**

Family Name	Given Name	Date of Birth
1.		
2.		
3.		
4.		

**Previous GP name and address**


<b>Signed</b>		<b>Date</b>	
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Please return this fax to acknowledge you have received the request to 09 411 5276, or post to Silver Fern Medical at the above address.

Practice Stamp

have received your request for the above patient's notes

We will be posting patient notes **or** sending them via EDI to EDI address silverfe (please circle one)