



VICTORIA PARK MEDICAL SUITES ENROLMENT FORM

5, Vernon Street, Auckland City, Auckland 1010

Phone: 09 557 3333 Fax: 09 557 3334

File No.
EDI vparkmed

				* NHI			
Title		* First Name(s)		* Family Name			
Other Names Known By (eg. maiden name, etc). Please tick the name you prefer to be known as				* Date of Birth		____/____/____ Day Month Year	
* Gender		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse (please state)		* Place & Country of Birth			
* Physical Address		Street number _____ Name of Street _____ Suburb _____ City/Town _____ Postcode _____		Occupation			
Postal Address				* High User Health Card Card Number & Expiry Date:		YES / NO	
				Community Services Card Card Number & Expiry Date:		YES / NO	
Contact Details		Day Phone	Night Phone	Mobile No (tick box to accept txts) <input type="checkbox"/>		Email (tick box to accept emails) <input type="checkbox"/>	
Emergency contact		Name of person to contact		Relationship		Phone Number	

* Which ethnic group do you belong to? Tick the space or spaces which apply to you		Smoking Status		* Eligibility (see over page) I confirm that, if requested, I can provide proof of my eligibility. I agree to inform the practice of any changes in my eligibility.	
<input type="checkbox"/> New Zealand European <input type="checkbox"/> Māori Iwi: <input type="checkbox"/> Samoan <input type="checkbox"/> Cook Islands Maori <input type="checkbox"/> Tongan <input type="checkbox"/> Niuean <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Other such as DUTCH, JAPANESE, TOKELAUAN, FIJIAN Please state: _____		<input type="checkbox"/> Current <input type="checkbox"/> Ex-Smoker Date Quit _____ <input type="checkbox"/> Never Smoked		* Eligible under criteria (enter applicable letter from list over page) * I have read and agree to the Enrolment Process, the Health Information Privacy Poster/Statement May 2026, and Patient Experience Survey. (Tick) NOT Eligible (Tick if not eligible under any criteria over page)	
		Transfer of Records <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable			
		In order to get the best care possible, I agree to the transfer of my records from my previous Doctor. I understand I will be removed from their practice register. Doctor's Name: Address / Location: Phone/Fax:			
* SIGNATURE				* DATE	
				____/____/____ Day Month Year	

OR Signed by AUTHORITY¹¹ An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Full Name of Authority	Contact Phone Number	Relationship
Address	Signature of Authority	____/____/____ Day Month Year
Detail the basis of authority (e.g. parent of a child under 16):		

Please read this sheet and identify on your enrolment form which criteria provides your eligibility to funded health services

Enrolment in the Practice / Primary Health Organisation (PHO)

I am eligible to enrol because I live in New Zealand⁹ and meet one of the following criteria:

- a) I am a New Zealand citizen OR
- b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) OR
- 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 OR
- 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) OR
- e) I am an interim visa holder¹⁰ who was eligible immediately before my interim visa started OR
- 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 OR
- 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
- 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) OR
- i) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme OR
- 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.

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 ongoing 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, PHO and National Enrolment Service Registers.

I understand that if I visit another 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, and their contact details.

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 eligibility.

HEALTH INFORMATION PRIVACY

I agree to the practice sharing my health information with other health providers involved in my healthcare. 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.

I also agree to my information being used for practice quality/audit activities and to being included in the practice screening, recall and health programmes.

I have been informed of the Health Information Privacy statement posters.

I have read and understood the Enrolment Process and Health Information Privacy Statement, including how the practice collects health information directly from me and may receive health information about me from other health providers, agencies, whānau/caregivers, or other sources involved in my care, safety, enrolment, funding, screening, recall, audit, quality improvement, or legal obligations.

⁹ The definition residing in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months

¹⁰ If a person has an interim visa this means they are waiting for Immigration to finish processing an application as Immigration issues interim visas if the old visa has run out but the new visa is still being processed. To determine the eligibility of an interim visa holder you should look at what their eligibility status was immediately prior to being issued the interim visa. For example, the person had a two year work permit and has been issued with an interim visa while waiting for their application for another two year work permit to be processed. Immigration usually issues Interim visas in a letter form.

¹¹An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.