PATIENT ENROLMENT FORM

Ostend Medical Centre

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Edi:- ostend

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ProCare

Fields with * are compulsory	*Anyone over age of 16 years must complete their own enrolment form*	NHI *(Office use only)*

Name Title	* Given name	* Other given name(s)	* Family name
Other name(s) (eg. maiden name) Please tick the name you prefer to be known as			
Birth details	* Day / Month / Year of birth	* Place of birth	* Country of birth
Gender	* ☐ Male ☐ Female ☐ Gender diverse (please state)		Occupation

Usual residential address	* House (or RAPID) number and street name	* Suburb/rural location	* Town / city and postcode
Postal address (if different from above)	House number and street name or PO box number	Suburb/rural delivery	Town / city and postcode
Contact details	Mobile phone / Home phone	Email address	
Emergency contact	Name	Relationship	Mobile (or other) phone

Transfer of records

In order to get the best care possible, I agree to the Practice obtaining my records from my previous doctor. I also understand that I will be removed from their practice register.

☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
Previous doctor and/or Practice name	Address / location	

Ethnicity Details

Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you

- ○ **New Zealand European**
- ○ **Māori**
- ○ **Samoan**
- ○ **Cook Island Māori**
- ○ **Tongan**
- ○ **Niuean**
- ○ **Chinese**
- ○ **Indian**
- ○ **Other** (such as Dutch, Japanese, Tokelauan). Please state

Community Services Card	☐ Yes	☐ No
Day / Month / Year of Expiry	Card Number	
High User Health Card	☐ Yes	☐ No
Day / Month / Year of expiry	Card number	
Do you smoke?	☐ Yes	☐ No (ex-smoker) ☐ Never
How did you hear about us?		

Please turn over