



Glen Innes Health Centre P O Box 18-303 Glen Innes EDI: ngatiwha Ph:578-0941 Fax: 521-0738	Otahuhu Health Centre P O Box 22-637 Otahuhu EDI:otahuhun Ph: 578-0941 Fax: 276-1191	Orakei Health Clinic P O Box 42-183 Orakei EDI: ngatiwha Ph: 578-0941 Fax: 521-4692
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We would appreciate receiving MT32 Patient Medical Notes electronically

PHO Enrolment Registration/Request for Medical Notes

Patient /Account Holder Details

Please Circle: Miss Mrs Ms Mr Gender Female / Male NZ citizen/Resident: Yes No

Family Name: _____ First Name: _____

Home Address St: _____ Suburb: _____ City: _____

Day ph: _____ A/H ph: _____ Date of birth: _____ Ethnicity: _____

CSC no: _____ Exp: _____ HUSC no: _____ Exp: _____

Winz No: _____

NOK Name: _____ Address: _____ Phone: _____ Relationship: _____

Dependants (must be under 16yrs)

Gender Ethnicity

Family Name: _____ First Name: _____ DOB: _____ M/F _____

Family Name: _____ First Name: _____ DOB: _____ M/F _____

Family Name: _____ First Name: _____ DOB: _____ M/F _____

Family Name: _____ First Name: _____ DOB: _____ M/F _____

I understand by signing this enrolment form:

- I have nominated Ngati Whatua O Orakei Health as my/our Primary Care Provider.
- I intend to use this practice as my/our usual provider of primary health care services.
- I understand that as Ngati Whatua O Orakei Health do not operate accounts and I am required to pay for my visit prior to leaving.
- Enrolment can only be with one practice, if I enrol in another practice I will not be entitled to reduced fees at Ngati Whatua O Orakei Health.
- If I do attend another practice Ngati Whatua O Orakei Health will be informed of the date of visit.
- This practice is a member of Tamaki Healthcare PHO. I/we can un-enrol at anytime.
- For funding and planing purposes, my/our enrolment/register information will be disclosed to Tamaki Healthcare PHO, Auckland District Health Board, and Ministry of Health.

By signing this form I Authorise the TRANSFER of my/our medical records to Ngati Whatua O Orakei Health From:

Previous GP Name: _____ Address: _____ Ph: _____

Patients Signature: _____ **Date:** _____

Reception to complete before scanning into Medtech32:

Transfer request: Date faxed: _____ GP Fax no: _____ Staff name: _____