Office use only			
Signed & Dated	☐	Faxed	☐
Visa & Passport	☐	Scanned	☐
NHI	☐	Text C	☐
Request Notes	☐	Portal C	☐
Enrolled	☐		
Entered			

PATIENT ENROLMENT FORM

ProCARE

AUCKLAND FAMILY MEDICAL CENTRE

Dr Sheelagh James #16157 ☐
Dr John McCartie - #13621 ☐
Dr Phillipa Murray - #18233 ☐
Dr Rebecca Little - #69391 ☐

auckfamc	**94 Remuera Road, Remuera 1050**	**524 6249**	**524 5230**	
EDI Number	Address	Phone Number	Fax Number	NHI *(Office use only)*

Legal Name	(Title)	Given Name	Other Given Name(s))	Family Name
Other Name(s) (e.g. 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 **Do you wish to receive text messages yes no**	Home Phone	Email Address
Emergency Contact	Name	Relationship	Mobile (or other) Phone

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

Are you a smoker? Yes No Never If yes would you like help to quit.

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
- ◯ Maori
- ◯ Samoan
- ◯ Cook Island Maori
- ◯ Tongan
- ◯ Niuean
- ◯ Chinese
- ◯ Indian

Other (such as Dutch, Japanese