

PRACTICE ENROLMENT FORM

Legal Name	Title: Mr/Mrs/Ms	Surname: (complete below)	First Name:	
			Middle Name:	
Marital Status		Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/>		
NHI: (office use only)			Date of Birth:	Day
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse (<i>please state</i>)				Month
				Year of Birth
			Place of Birth:	
Occupation:			Country of Birth:	
Residential Address	Street Number:		Street Name:	
	Suburb:		City:	Postcode:
Postal Address (if different to above)				
Home Phone:		Work:	Mobile	
Email:			Do you smoke?	
Do you agree to receive text messages?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes Do you want to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never smoked (Not smoked more than 100 tobacco cigarettes in your life) <input type="checkbox"/> Ex-smoker (Quit date _____)	
Do you agree to receive emails?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Next of Kin / Emergency Contact Details	Title: Mr/Mrs/Ms	Surname: (complete below)	First Name:	Relationship to Patient
	Address			
	Phone		Mobile	
Community Services Card				
<input type="checkbox"/> Yes / <input type="checkbox"/> No				
Card number:				
Card Expiry Date:				
High User Health Card				
<input type="checkbox"/> Yes / <input type="checkbox"/> No				
Card number:				
Card Expiry Date:				
Which ethnic group(s) do you belong to? Tick the space or spaces which apply to you				
<input type="radio"/> New Zealand European <input type="radio"/> Maori - Hapu/Iwi affiliation <input type="radio"/> Samoan <input type="radio"/> Cook Island Maori <input type="radio"/> Tongan <input type="radio"/> Niuean <input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Other such as (Dutch, Japanese, Tokelauan) Please state _____				
Transfer of records				
In order to get the best care possible, I agree to this Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable Previous Doctor's name: Address: Phone: Signature _____ (agreement for transfer of records)				

My declaration of entitlement and eligibility

I am entitled to enrol because I am residing permanently in New Zealand

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

I am eligible to enrol because:

A	I am a New Zealand citizen <i>(If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below)</i>	<input type="checkbox"/>
---	---	--------------------------

If you are **not a New Zealand Citizen**, please tick which eligibility criteria applies to you (B-J) below:

B	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
E	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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 in the control of the Chief Executive of the Ministry of Social Development	<input type="checkbox"/>
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)	<input type="checkbox"/>
I	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>

I confirm that, if requested, I can provide proof of my eligibility

we will retain a copy for eligibility purposes only

Evidence Sighted (office use only)

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/health care services.
- I understand** that by enrolling with this practice I will be included in the enrolled population of Auckland Primary Health Organisation, and my name, address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers.
- I understand** that if I visit another health care 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 along with the PHO's name and contact details.
- I have read and I agree** with the Use of Health Information Statement. 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 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 contact details and entitlement and/or eligibility to be enrolled.

Signatory Details	Signature _____	Date ____/____/____	<input type="checkbox"/> Self-Signing	<input type="checkbox"/> Authority
--------------------------	-----------------	---------------------	--	---------------------------------------

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

Authority Details <i>(where signatory is not the enrolling person)</i>	Full Name:	Relationship:
	Contact Phone:	Basis of authority: <i>(e.g. parent of a child under 16 years of age)</i>