


Pirirakau Hauora Enrolment Form

NHI: _____

Legal Name	<small>(Title)</small>	Given Name*	Other Given Name(s)*		Family Name*
Other Name(s)		Preferred Name	Other Given Name(s)		Other Family Name (eg; Maiden Name)
Birth Details		Day / Month / Year of Birth*	Place of Birth*		Country of Birth*
Gender		<input type="checkbox"/> *Male	<input type="checkbox"/> *Female	<input type="checkbox"/> *Gender diverse (please state)	Occupation
Iwi				Hapū	
Community Services Card		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number
High User Health Card		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number
Usual Residential Address	House (or RAPID) Number and Street Name*			Suburb*	Town / City and Postcode*
Postal Address <small>(if different from above)</small>	House Number and Street Name or PO Box Number			Suburb	Town / City and Postcode
Contact Details		Mobile Phone	Home Phone	Email Address	
Emergency Contact		Name		Relationship	Mobile (or other) Phone
Ethnicity Details <small>Which ethnic group(s) do you belong to? Tick the space or spaces which apply to you</small>		<input type="radio"/> Maori (21) <input type="radio"/> Cook Island Maori (32) <input type="radio"/> Niuean (34) <input type="radio"/> Tongan (33) <input type="radio"/> Samoan (31) <input type="radio"/> New Zealand European (11) <input type="radio"/> Indian (43) <input type="radio"/> Chinese (42) <input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please State:			
		Are you a smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Past <input type="checkbox"/> Recently quit Would you like us to assist you to stop smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No I agree to be on the recall list for medical screening <input type="checkbox"/> Yes <input type="checkbox"/> No I agree to receive a reminder text for medical recalls <input type="checkbox"/> Yes <input type="checkbox"/> No Women Aged 45-69 years: I agree to being enrolled with Breastsreen Aotearoa <input type="checkbox"/> Yes <input type="checkbox"/> No Women Aged 20-69 years: I agree to being enrolled with the National Cervical Screening Programme <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from any known illnesses such as diabetes, asthma, heart condition? Please stipulate: Note: GP Services enrolment payment terms and conditions: <input type="checkbox"/> I agree the practice (GP Services) is entitled to charge a fee for services and I understand that I am financially responsible for payment of those services <input type="checkbox"/> I understand that payment is to be made on the day			
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.			
		<input type="checkbox"/> Yes, please request transfer of my records		<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
Previous Doctor and/or Practice Name				Address / Location	
 Ngā Mataapuna Oranga PHO 157 Fraser Street Tauranga 3110 Ph: 07 579 4930 Office use only		<input type="checkbox"/> Tauranga Moana City Clinic Ph: 07 571 2017	11 Tebbs Lane, 53 Courtney Rd, Gate Pa, Tauranga 3112		EDI Address: wsiwicts Dr Maura Conneely #49510
		<input type="checkbox"/> Te Akau Hauora Ph: 07 574 9830	95A Hartford Ave, Papamoa 3118		EDI Address: wsiwicts Dr David Spear #39801
		<input type="checkbox"/> Waitaha Health Ph: 07 573 0141	Centre Shop 9, Palmer Place, Jellicoe Street, Te Puke 3119		EDI Address: wsiwicts Dr Simon Roberts #15181
		<input type="checkbox"/> Pirirakau Hauora Ph: 07 552 4573	3 Lochhead Rd, Te Puna, Tga 3176		EDI Address: piriraka Dr Nigel Bruce NZMC #11545
<input type="checkbox"/> Enrolling	<input type="checkbox"/> Enrolling with GP Clinic	Internal Referral to: <input type="checkbox"/> GP Clinic		<input type="checkbox"/> Mental Health <input type="checkbox"/> Addiction Service	
<input type="checkbox"/> Re-Enrolment	<input type="checkbox"/> OR Tamariki Ora Well Child Service (TORA)	<input type="checkbox"/> TORA		<input type="checkbox"/> Dental Service 0-5 years <input type="checkbox"/> Dental Service 13-18 years	
<input type="checkbox"/> Casual/Emergency	<input type="checkbox"/> OR Community Nursing (CMNS)	<input type="checkbox"/> CMNS		<input type="checkbox"/> Kaiārahi Service <input type="checkbox"/> Other Service	

My declaration of entitlement and eligibility*

* = mandatory fields

I am entitled to enrol because I am residing permanently in New Zealand* <i>The definition of residing permanently in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months</i>	<input type="checkbox"/>
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I am eligible to enrol because:

a	I am a New Zealand citizen (If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below)*	<input type="checkbox"/>
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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 current work visa/permit and can show that I am legally able to be in New Zealand for at least 2 years (previous visas/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

Evidence sighted (office use)

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 on-going 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 Ngā Mataapuna Oranga Primary Health Organisation (PHO) 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 healthcare 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 this Practice shares limited information with the BOP District Health Board (BOPDHB).

I understand that this Practice shares my information with other health professionals that are involved in my care. Other health professionals may add to my health records during services provided to me and use that information to provide appropriate care.

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. The survey provides important information that is used to improve health services.

I agree to participate in the Patient Survey
 I do not wish to participate in the Patient Survey

I agree to inform the Practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

Signatory Details	*Signature	*Day / Month / Year	<input type="checkbox"/>	<input type="checkbox"/>
			*Self-Signing	*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	Full Name	Relationship	Contact Phone
<i>(where signatory is not the enrolling person)</i>	Basis of authority (e.g. parent of a child under 16 years of age)		
Authority Details			