Enrolment Form

Legal Name (Title)		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	☐ Male ☐ Female ☐ Gender diverse (please state)			Occupation
Iwi			**Hapū**	
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	
Usual Residential Address	House (or RAPID) Number and Street Name		Suburb	Town / City and Postcode
Postal Address (if different from above)	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
Which ethnic group(s) do you belong to?
Tick the space or spaces which apply to you

- ☐ Maori (21)
- ☐ Cook Island Maori (32)
- ☐ Niuean (34)
- ☐ Tongan (33)
- ☐ Samoan (31)
- ☐ New Zealand European (11)
- ☐ Indian (43)
- ☐ Chinese (42)
- ☐ Other (such as Dutch, Japanese, Tokelauan). **Please State:**

Are you a smoker? ☐Yes ☐ No ☐ Past ☐ Recently quit
Would you like us to assist you to stop smoking? ☐ Yes ☐ No

I agree to be on the recall list for medical screening ☐ Yes ☐ No
I agree to receive a reminder text for medical recalls ☐ Yes ☐ No

Women Aged 45-69 years:
I agree to being enrolled with Breastscreen Aotearoa ☐ Yes ☐ No

Women Aged 20-69 years:
I agree to being enrolled with the National Cervical Screening Programme ☐ Yes ☐ No

Do you suffer from any known illnesses such as diabetes, asthma, heart condition**?**
Please stipulate:

Note: GP Services enrolment payment terms and conditions:
☐ 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
☐ 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.*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
NHI & Office Use	**Previous Doctor and/or Practice Name**	**Address / Location**	

Ngā Mataapuna Oranga
PHO
157 Fraser Street
Tauranga 3110
Ph: 07 579 4930

☐**Tauranga Moana City Clinic**	11 Tebbs Lane, 53 Courtney Rd, Gate Pa, Tauranga 3112 Ph: 07 571 2017	EDI Address: **wsiwicts** Dr Malcom Christie #18782
☐**Te Akau Hauora**	95A Hartford Ave, Papamoa 3118 Ph: 07 574 9830	EDI Address**: wsiwicts** Dr David Spear #39801
☐**Waitaha Health**	Centre Shop 9, Palmer Place, Jellicoe Street, Te Puke 3119 Ph: 07 573 0141	EDI Address: **wsiwicts** Dr Jethro Leroy #38589
☐**Pirirakau Hauora**	3 Lochhead Rd, Te Puna, Tga 3176 Ph: 07 552 4573	EDI Address: **piriraka** Dr Nigel Bruce NZMC #11545

Office use only

☐	Enrolling	☐	**Registering with** GP Clinic	**Internal Referral to**: ☐ GP Clinic	☐ Mental Health ☐ Addiction Service
☐	Re-Enrolment	☐	**OR** Tamariki Ora Well Child Service (TORA)	☐ TORA	☐ Dental Service 0-5 years ☐ Dental Service 13-18 years
☐	Casual/Emergency	☐	**OR** Community Nursing (CMNS)	☐ CMNS	☐ Kaiarahi Service ☐ Other Service

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 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** *(If yes, tick box and proceed to **I confirm that, if requested, I can provide proof of my eligibility** below)**	☐

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)	☐
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	☐
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)	☐
e	I am an interim visa holder who was eligible immediately before my interim visa started	☐
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	☐
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	☐
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)	☐
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	☐
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	☐

☐ ***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 Enter Clinic Name _____ I will be included in the enrolled population of Nga 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 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 my information with the BOP District Health Board (BOPDHB) and other health professionals that are involved in my care. The BOPDHB and 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	☐ 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 *(where signatory is not the enrolling person)*	Full Name	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age)		
Authority Details			