

# Enrolment Form

## OFFICE USE ONLY

## NHI :

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|--|-------------|---|-------------|
| <input type="checkbox"/> Dr Caitlin Corlett  | NZMC: 83998 | <input type="checkbox"/> Dr Terrillian Hui    | NZMC: 75705 |
| <input type="checkbox"/> Dr Calum Cunningham | NZMC: 78477 | <input type="checkbox"/> Dr James Moody       | NZMC: 71649 |
| <input type="checkbox"/> Dr Richard Lowe     | NZMC: 71629 | <input type="checkbox"/> Dr Logitha Sritharan | NZMC: 76063 |
| <input type="checkbox"/> Dr Gary MacLachlan  | NZMC: 15793 | <input type="checkbox"/> Dr Michael Epiha     | NZMC: 84318 |
| <input type="checkbox"/> Dr Sam Burrigde     | NZMC: 71551 | <input type="checkbox"/> OTHER:               | NZMC:       |
| <input type="checkbox"/> Dr Bobae Lee        | NZMC: 84372 |   |             |

<b>Name</b>	Family Name (Surname)	Given Name (First Name)	Other Given Name(s)
Please tick the name you prefer to be known as			
<b>Birth Details</b>	Day / Month / Year	Place of Birth	Country of Birth
<b>Gender</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse
			Occupation
<b>Usual Residential Address</b>	e.g. 223 Stoddard Road, Mt Roskill, Auckland 1041		
<b>Postal Address</b>			
<b>Contact Details</b>	Mobile phone	Home phone	Email address
<b>Emergency Contact</b>	Name	Relationship	Phone
<b>Transfer of Records</b>	<i>In order to get the best care possible, I agree to GP Central obtaining my records from my previous doctor. I also understand that I will be removed from my previous GP practice's register.</i>		
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor's name and Clinic's name/address:		
	Signature:		

<b>Ethnicity Details</b>		Do you agree to receive texts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Which ethnic group(s) do you belong to? <b>Tick the space or spaces which apply</b>	<input type="checkbox"/> New Zealand European	Community Services Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="checkbox"/> Māori	Card number and expiry:			
	Iwi: _____	High User Health Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Hapū: _____	Card number and expiry:			
	<input type="checkbox"/> Samoan	Do you smoke?	<input type="checkbox"/> Never	<input type="checkbox"/> Ex-smoker	<input type="checkbox"/> Yes
	<input type="checkbox"/> Cook Island Māori	<b>Register for MyIndici?</b>			
	<input type="checkbox"/> Tongan	Secure <b>patient portal</b> - to access your medical records and manage your health online			
<input type="checkbox"/> Niuean	<input type="checkbox"/> Yes			<input type="checkbox"/> No	
<input type="checkbox"/> Chinese					
<input type="checkbox"/> Indian					
<input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan). Please state:					

## Declaration of Entitlement and Eligibility

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 NZ 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 <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"/>
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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 permanent resident visa (or a residence permit if issues 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 permit 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 in 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 can confirm that, if requested, I can provide proof of eligibility	<input type="checkbox"/>	Evidence sighted <i>(office use only)</i>
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### My agreement to the enrolment process (parent or caregiver to sign if you are under 16 years)

**I intend to use this practice** as my regular 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 with the Primary Health Organisation (PHO) this practice belongs to, and my name, address and other identification details will be included in the Practice, PHO and National Service Registers.

**I understand** that if I visit another healthcare provider where I am 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	Day / Month / Year	<input type="checkbox"/> Self-signing	<input type="checkbox"/> Authority
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***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 (when 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)			