



**HOKIANGA HEALTH ENTERPRISE TRUST**  
**HAUORA HOKIANGA INTEGRATED PHO**  
**Patient Enrolment Form**

FCLE02

Completion and signing of this form will register you with Hauora Hokianga PHO as your usual provider of 24 hour Primary Health Care services. If you are resident in Hokianga, unless you indicate otherwise you will also be automatically enrolled with Hokianga Health Enterprise Trust for community health services. Please use this form to also register any children who are under 16 years who are in your custody or any dependants under your care.

Family name	First names	Date of birth	M/F

Full Residential Address (include RAPID or street number)	Postal Address (if different)	Phone
		Home:
		Work:
		Mobile:

Are you, or have you been, known by any other names? (eg maiden name) \_\_\_\_\_

Are you a 'Permanent Resident' in New Zealand? Yes / No

Which ethnic group do you belong to? (Mark the space or spaces that apply to you)

NZ European       Maori       Samoan       Cook Island Maori   
 Tongan       Niuean       Other  
 (Please state) \_\_\_\_\_

**If changing from another practice, please write the name and address of that practice/doctor**

\_\_\_\_\_

If you are enrolled with another PHO, but you reside in Hokianga and wish to register for our community services only, please mark this box

**I understand that:**

- Hauora Hokianga is a Primary Health Organisation (PHO). I have been informed of the implications of enrolment with a PHO and I intend to use Hauora Hokianga Integrated PHO as my usual provider of primary health care services. When I enrol with Hauora Hokianga Integrated PHO, I will be removed from any PHO with which I was previously enrolled.
- Any information provided by me will be confidential under the terms of the Health Information Privacy Code 1994
- The Ministry of Health (MoH) will attach a National Health Index (NHI) number to my record (or update existing information)
- The practice register and anonymous information may be used by the MoH, DHB and/or the PHO for administrative, funding, planning or audit purposes
- If I enrol with another PHO, my previous PHO will be informed of this, but they will not be given the name of my new PHO.
- If I visit & use another PHO, my previous PHO will be informed of the date of the visit and my NHI number, but no other details
- My primary health care provider may send my health care information (confidentially) to other health professionals who are directly involved in my health care and treatment.

I declare that the information I have given is true and complete to the best of my knowledge. I authorise Hauora Hokianga PHO to request my medical records from my previous doctor (where applicable)

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please return completed form to: Hokianga Health, Private Bag, Kaikohe**  
**Phone: (09)4057 709 Fax: (09)4057 875 Email: hokiangahealth@xtra.co.nz**