Hauora Hokianga

Hokianga Health

163 Parnell Street
Rawene 0443

Private Bag 753
Kaikohe 0440
Ph: (09) 405 7709
Fax: (09) 405 7875

ENROLMENT FORM

Fields with * are compulsory	***Anyone over age of 16 years must complete their own enrolment form***	* NHI *(Office use only)*

Name	* **Title**	* **Given Name**	* **Other Given Name(s)**	* **Family Name**
Other Name(s) (eg. maiden name) Please tick the name you prefer to be known as				
Birth Details	* **Day / Month / Year of Birth**	* **Place of Birth**	* **Country of birth**	
Gender	* ☐ Male ☐ Female ☐ Gender Diverse		* **Occupation**	

Usual Residential Address	* **House (or RAPID) Number and Street Name**		* **Suburb/Rural Location**	* **Town / City and Postcode**
Postal Address (if different from above)	House Number and Street Name or PO Box Number		Suburb/Rural Delivery	Town / City and Postcode
Contact Details	Mobile Phone	Home Phone	Email Address	
Emergency Contact	Name		Relationship	Mobile (or other) Phone

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
	Previous Doctor and/or Practice Name	Address / Location	

	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
	Ethnicity Details Which ethnic group(s) do you belong to? ***Tick the space or spaces which apply to you***	
	☐ **NZ European** ☐ **Maori** ☐ **Samoan** ☐ **Cook Island** ☐ **Tongan** ☐ **Niuean** ☐ **Chinese**	
	☐ **Indian** ☐ **Other** ……..	

* 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 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 on-going provider of general practice / GP / health care services.

I understand that by enrolling with **Hokianga Health** I will be included in the enrolled population of **Te Tai Tokerau 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 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**	* **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)		