

 <b>Hauora Hokianga</b> Hokianga Health	<b>HOKIANGA HEALTH</b> 163 Parnell Street, Rawene 0473 – Private Bag 753, Kaikohe 0440 Phone: (09)4057709 Fax: (09)4057875 EDI: hokihlth GP2GP: Cheryl Turner nznc: 180729	 <b>Mahitahi Hauora</b>
<b>ENROLMENT FORM</b>		

Fields with * are compulsory	Anyone over age of 16 years must complete their own enrolment form	NHI (Office use only)
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<b>Name</b>	Title	* Given Name	* Other Given Name(s)	* Family Name
<b>Other Name(s)</b> (eg. maiden name) Please tick the name you prefer to be known as				
<b>Birth Details</b>		* Day / Month / Year of Birth	* Place of Birth	* Country of birth
<b>Gender</b>		* <input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender Diverse (please state) Occupation

<b>Usual Residential Address</b>	* House (or RAPID) Number and Street Name	* Suburb/Rural Location	* Town / City and Postcode
<b>Postal Address</b> (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

<b>Contact Details</b>	Mobile Phone	Home Phone	Email Address
<b>Emergency Contact</b>	Name		Relationship Mobile (or other) Phone

<b>Transfer of Records</b>	<i>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.</i>		
	<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

<b>Ethnicity Details</b> Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i> <input type="radio"/> New Zealand European <input type="radio"/> Maori Iwi: _____ Hapu: _____ <input type="radio"/> Samoan <input type="radio"/> Cook Island Maori <input type="radio"/> Tongan <input type="radio"/> Niuean <input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state _____	<b>Community Services Card</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Day / Month / Year of Expiry	Card Number
	<b>High User Health Card</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Day / Month / Year of Expiry	Card Number
	<b>Smoking Status</b> <input type="checkbox"/> Never Smoked <input type="checkbox"/> Smoker <input type="checkbox"/> Ex-Smoker Number of years since quitting _____ Would you like help to stop smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	

*	<b>My declaration of entitlement and eligibility</b>	*
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<b>I am entitled to enrol</b> 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	<b>I am a New Zealand citizen</b> <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 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 work visa/permit and can show that I am able to be in New Zealand for at least 2 years (previous 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 <b>OR</b> 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"/>

<b>I confirm</b> that, if requested, I can provide proof of my eligibility	<input type="checkbox"/>	Evidence sighted ( <i>Office use only</i> )
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<b style="font-size: 1.2em;">My agreement to the enrolment process</b> <b>NB. Parent or Caregiver to sign if you are under 16 years</b>
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**I intend to use this practice** as my regular and ongoing 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 this practice's Primary Health Organisation (PHO) **Mahitahi Hauora**, 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 understand** 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.

<b>Signatory Details</b>	* <b>Signature</b>	* <b>Day / Month / Year</b>	<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.**

<b>Authority Details</b> <i>(where signatory is not the enrolling person)</i>	Full Name	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age)		