

 Hauora Hokianga Hokianga Health		HOKIANGA HEALTH 163 Parnell Street, Rawene 0473 – Private Bag 753, Kaikohe 0440 Phone: (09)4057709 Fax: (09)4057875 EDI: hokihlth			
ENROLMENT FORM					
<i>Please note: To enrol with Hokianga Health, you must permanently live in the Hokianga area and provide proof of residence.</i>					
Fields with * are compulsory		<i>Anyone over age of 16 years must complete their own enrolment form</i>			NHI (Office use only)
Name	Title	* Given Name	* Other Given Name(s)	* Family Name	
Other Name(s) (e.g. maiden name)		* Given Name	* Other Given Name(s)	* Family Name	
Birth Details		* Day / Month / Year of Birth	* Place of Birth	* Country of birth	
Gender	* ☐ Male ☐ Female ☐ Gender Diverse (please state): _____			Occupation	
Usual Residential Address	* House (or RAPID) Number and Street Name		* Suburb/Rural Location	* Town / City and Postcode	
Postal Address (if different from above)					
Contact Details	Mobile Phone		Home Phone	Email Address	
Emergency Contact	Name		Relationship	Mobile (or other) Phone	
Transfer of Records	<i>In order to get the best care possible, I agree to the Practice obtaining my records from my previous Medical Professional (Doctor). I also understand that I will be removed from their practice register.</i>				
	☐ Yes, please request transfer of my records		☐ No transfer	☐ Not applicable	
	Previous Doctor and/or Practice Name		Address / Location		
Would you like to sign up for Health365, our online patient portal where you can view lab results, request repeat prescriptions and access general health information?				☐ Yes	☐ No
Ethnicity Details Which ethnic group(s) do you belong to? <i>(Tick the one/s which apply to you)</i>		Which services at Hauora Hokianga do you intend to use?		Community Services Card	
☐ New Zealand European ☐ Maori Iwi: _____ Hapu: _____ ☐ Samoan ☐ Cook Island Maori ☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian ☐ Other Please state: _____		☐ General Practitioner (GP) ☐ Mental Health Services ☐ Immunisation Services ☐ Diabetes Support ☐ Cancer Care ☐ Toki Rau (Stop Smoking) ☐ Te Ao Mārama (Maternity Dept.) ☐ Preventative Screenings (Cancer) ☐ Physiotherapist ☐ Poua Raa Rongoā Whakaora (traditional healing) ☐ Other (Please state: _____)		☐ Yes ☐ No Day / Month / Year of Expiry Card Number High User Health Card ☐ Yes ☐ No Day / Month / Year of Expiry Card Number Smoking Status ☐ Never Smoked ☐ Smoker ☐ Vape ☐ Ex-Smoker Number of years of smoking: _____ Number of years since quitting: _____ Approx. how many cigarettes per day: _____ Would you like help to stop smoking ☐ Yes ☐ No	

My 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 New Zealand for at least 183 days in the next 12 months</i>	☐
---	--------------------------

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

(Parent or Caregiver to sign if you are under 16 years)

- I intend to use Hauora Hokianga as my regular and ongoing provider of general practice (GP)/ health care services.
- I understand that Hauora Hokianga is a not-for-profit, community-owned organisation providing health and wellbeing services to the Hokianga community.
- I understand that by enrolling with Hauora Hokianga, I will be included in the enrolled population of a Primary Health Organisation (PHO) that Hauora Hokianga is affiliated with. A PHO is an organisation that supports and coordinates primary health care services and helps administer publicly funded primary care services in New Zealand. I understand that my name, address, and other identification details will be included on the Hauora Hokianga Practice Register, the PHO register and the National Enrolment Service Register.
- I understand that if I visit another health care provider where I am not enrolled, I may be charged a higher fee.
- I confirm that I have been given information about the benefits and implications of enrolment and the services Hauora Hokianga.
- I understand that I can change my enrolled health care provider at any time by completing a new enrolment form with another practice.
- I have read and 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 Hauora Hokianga 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 or opt out of the survey by informing Hauora Hokianga. The survey provides important information used to improve health services.
- I understand that Hauora Hokianga may use approved digital tools, including Heidi Health AI Scribe, to support clinical documentation. This tool assists clinicians in recording consultation notes and does not replace clinical judgement. My consent will be obtained before it is used during my consultation.
- I understand that Hauora Hokianga supports the teaching and training of health professionals. Students or trainees may be present during consultations and I will always be asked for my consent beforehand. I may decline at any time.
- I agree to inform Hauora Hokianga of any changes to 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)		