ENROLMENT FORM

Tahunanui Medical Centre

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- ☐ Dr Jo Knight
- ☐ Dr Steve Cameron
- ☐ Dr Stephen Neas
- ☒ Dr Sue Boswell
- ☒ Dr Kirstie Harris
- ☐ Dr Frith Dollimore
- ☐ Dr Amy Mannering
- ☐ Dr Rebecca Billowes

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
Birth Details		Preferred name	★ Day / Month / Year of Birth	★ Place and 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)	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/Next of Kin	Name		Relationship	Mobile (or other) Phone

Transfer of Records	*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, as I am only able to be enrolled at one practice at a time in New Zealand.*		
	☐ 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 ethnicity group do you belong to? Tick the spaces that apply to you

☐ 11. New Zealand European ☐ 31. Samoan ☐ 32. Cook Island Maori ☐ 33. Togan
☐ 21. Maori ☐ 34. Niuean ☐ 42. Chinese ☐ 43. Indian
Iwi/Tribe: ☐ Other: Please state

I Consent to receive Communication Via Email – Text – Patient Portal *Please tick applicable boxes to give your consent:*

☐ **Text Message** ☐ **Email (non-secure)** ☐ **Patient Portal** *(email address needed, only used by yourself) If you consent to the Patient Portal and are aged 16 years and older you will receive an activation code via email (check your junk mail), follow the step-by-step instructions to activate your account.*

☐ I agree to the transfer of my medical records from my previous GP.

☐ I confirm that I have read and accept the terms of trade and understand that payment is required at the time of consultation.

★Signature: _____ ★Day/Month/Year _____ ☐ Self-signing ☐ Authority

Authority: ★Full Name_____ ★Relationship:_____.

★ 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 <u>not</u> 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 current work visa/permit and can show that I am legally able to be in New Zealand for at least 2 years (previous visas / 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 & copied (*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 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) Nelson Bays Primary Health, and <u>my name address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers</u>.
I understand that if I visit another health care provider where I am not enrolled I may be charged a higher fee.
<u>I have been given information</u> about the <u>benefits and implications of enrolment</u> and the services this practice and PHO provides along with the PHO's name and contact details.
I have read and I understand the <u>Use of Health Information</u> 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 have read and I understand Tahunanui Medical Centres Terms of Trade.
I understand that the Practice participates in a national survey about your health care experience. Taking part in this survey is voluntary and all responses will be anonymous. I can decline the survey, or opt out 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:**