

	<h2 style="margin: 0;">ENROLMENT FORM</h2> <h3 style="margin: 0;">Tahunanui Medical Centre</h3> <p style="margin: 0;">23 Tahunanui Drive, Nelson 7011 Phone: 03-5485154, Fax: 03-5485960 EDI: tahunamc Email: admin@tahunamedical.co.nz Website: www.tahunamedical.co.nz</p>	<input type="checkbox"/> Dr Jo Knight <input type="checkbox"/> Dr Steve Cameron <input type="checkbox"/> Dr Stephen Neas <input type="checkbox"/> Dr Laura Judge <input type="checkbox"/> Dr Kirstie Harris <input type="checkbox"/> Dr Frith Dollimore <input type="checkbox"/> Dr Amy Mannering <input type="checkbox"/> Dr Rebekah 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
Gender	★ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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

Contact Details	Mobile Phone	Home Phone	Email Address
	Emergency Contact/Next of Kin		Mobile (or other) Phone
	Name	Relationship	

Transfer of Records	<i>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.</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	

Community Services Card	<input type="checkbox"/> Yes <input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number
High User Health Card	<input type="checkbox"/> Yes <input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number

★ Ethnicity Details <i>Which ethnicity group do you belong to? Tick the spaces that apply to you</i>	<input type="checkbox"/> 11. New Zealand European	<input type="checkbox"/> 31. Samoan	<input type="checkbox"/> 32. Cook Island Maori	<input type="checkbox"/> 33. Togan
	<input type="checkbox"/> 21. Maori	<input type="checkbox"/> 34. Niuean	<input type="checkbox"/> 42. Chinese	<input type="checkbox"/> 43. Indian
	iwi/Tribe: <input type="checkbox"/> 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 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 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)	<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 OR 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"/>

★ 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 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 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	<input type="checkbox"/> ★Self-Signing	<input type="checkbox"/> ★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 <i>(where signatory is not the enrolling person)</i>	★Full Name:	★Relationship:	★Contact Phone:
--	--------------------	-----------------------	------------------------