

**Tahunanui Medical Centre**  
23 Tahunanui Drive, Nelson 7011  
Phone: 03-5485154, Fax: 03-5485960, EDI: tahunamc

*Enrolling at Tahunanui Medical Centre means you are able to see any of our doctors  
but one will take overall responsibility for your on-going medical care*

**Who is your preferred doctor?** (see [www.tahunamedical.co.nz](http://www.tahunamedical.co.nz) for more information about our doctors)

Dr Jo Knight   Dr Steve Cameron   Dr Stephen Neas   Dr Sue Boswell   Dr Katie Maver   Dr Kirstie Harris   Dr Sarah Richards

**Please give us your details:**

Title \_\_\_\_\_ Surname\* \_\_\_\_\_ First Names\* \_\_\_\_\_

Street Address\* \_\_\_\_\_ Postal Address (if different from street address) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date of Birth\* \_\_\_\_\_ Place/Country of Birth\* : \_\_\_\_\_ Gender\* \_\_\_\_\_

Phone Home \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

**Next of Kin / Emergency Contact** – if you are completing this form on behalf of a child under 16 years and you have legal custody please put yourself

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_ Relationship \_\_\_\_\_

**Which Ethnic groups do you belong to?**

(Please tick all that apply)

- |   |  |  |
|---|--|--|
| 11. NZ European / Pakeha <input type="checkbox"/> | 34. Niuean <input type="checkbox"/>              | 43. Indian <input type="checkbox"/>                    |
| 12. Other European <input type="checkbox"/>       | 35. Tokelauan <input type="checkbox"/>           | 44. Other Asian <input type="checkbox"/>               |
| 21. NZ Māori <input type="checkbox"/>             | 36. Fijian <input type="checkbox"/>              | 51. Middle Eastern <input type="checkbox"/>            |
| Iwi/Tribe: _____                                  | 37 Other Pacific Island <input type="checkbox"/> | 52. Latin American / Hispanic <input type="checkbox"/> |
| 31. Samoan <input type="checkbox"/>               | 40. Asian not defined <input type="checkbox"/>   | 53. African <input type="checkbox"/>                   |
| 32. Cook Island Māori <input type="checkbox"/>    | 41. South East Asian <input type="checkbox"/>    | 61. Other ethnicity <input type="checkbox"/>           |
| 33. Tongan <input type="checkbox"/>               | 42. Chinese <input type="checkbox"/>             | 98. Declined to State <input type="checkbox"/>         |

**Who was your last GP or Medical Centre?** In order to get the best care, we ask you to consent to have your medical records transferred from your previous general practice; you will then no longer be enrolled with your previous doctor.

Name of previous GP or medical centre and address \_\_\_\_\_

**I confirm that I**

- intend to use Tahunanui Medical Centre as my usual provider of primary health care services and wish to enrol here;
- am eligible and entitled to enrol as per the eligibility criteria on the back of this form;
- intend to be living in NZ for at least 183 days during the next 12 months;
- understand the implications of enrolment listed on the back of this form;
- agree to the transfer of my medical records from my previous GP;
- will abide by the terms of trade displayed at Tahunanui Medical Centre; and
- have given information which is true and complete as far as I know.

**Signature** \* \_\_\_\_\_ **Date**\* \_\_\_\_\_

Where a person enrolling is under 16 years or is unable to sign, the declaration can be signed by a person with authority, in this case complete:

**Who signed the form?** \_\_\_\_\_ **What is your relationship with the person enrolling?** \_\_\_\_\_

**Please turn over....**

***In order to receive subsidised medical care you need to confirm that you meet the criteria, according to the Ministry of Health rules found at [www.moh.govt.nz/moh.nsf/indexmh/eligibility-direction](http://www.moh.govt.nz/moh.nsf/indexmh/eligibility-direction)***

**Please tick the Eligibility Criteria which is applicable to you:**

- ☐ New Zealand Citizen
- ☐ Ordinary resident in New Zealand
- i. Hold a residence permit and been lawfully in New Zealand for a minimum of 2 years or hold a current returning residents visa
  - ii. Australian citizen able to demonstrate intent to stay in New Zealand for a minimum of 2 years; or
  - iii. Work permit holder able to demonstrate lawfully able to be in New Zealand for a minimum of 2 years

Other \_\_\_\_\_

**Are you currently employed?** YES ☐ NO ☐

Please provide your employer details \_\_\_\_\_ Work Phone \_\_\_\_\_

**Do you have a Community Services Card?** YES ☐ NO ☐

Please provide card number: \_\_\_\_\_ Exp Date \_\_\_\_\_

## **Important Information:**

1. Tahunanui Medical Centre is a member of Nelson Bays Primary Health. I have been informed of the implications of enrolment with a Primary Health Organisation and I intend to use this practice as my usual provider of primary health care services.
2. For funding purposes, provision of the following information and its use as described below, is mandatory to enable me to receive subsidised funding pursuant to this enrolment process:

### **Non clinical information**

- a) The information on this form (including the name of my provider and the date of my last consultation), but not my health information, will be sent to the District Health Board or its agent to obtain subsidised funding on my behalf.
- b) The information I have provided on this form will be used by the Ministry of Health to give me a National Health Index (NHI) number or update my NHI information.
- c) If I enroll with another Primary Health Organisation, my previous or 'old' Primary Health Organisation will be informed of this change. They will not be informed of the name of my new Primary Health Organisation.
- d) If I visit another provider, the Primary Health Organisation I am enrolled with will be informed of the date of this visit and my NHI number but it will not receive the provider's name or my health information in relation to this visit.

### **Clinical information**

- e) My health information, which may include my name, may be sent to:
    - i. The Ministry of Health and District Health Boards to plan, monitor and fund future primary health care services, or
    - ii. The PHO if I am part of one of its programmes (e.g. Care Plus, diabetes) and it has obtained my consent for this purpose.
  - f) My primary health care provider may add to my health information during any treatment provided to me and may send my health information to other health professionals who are directly involved in my health care and treatment.
  - g) My health information may be viewed for claim verification purposes but only pursuant to the terms and conditions of Section 22G of the Health Act.
3. I will advise my practice if I decide to change to a different doctor/practice and will keep them updated with any changes to my circumstances such as moving house or new phone numbers.
  4. I have rights of access to, and correction of, my health information pursuant to rules 6 & 7 of the health Information Privacy Code.

**We expect to receive payment for our services on the day they are delivered**

#### **Office use only:**

Date \_\_\_\_\_ NHI \_\_\_\_\_

ID sighted & copied \_\_\_\_\_ Staff Initials \_\_\_\_\_

#### **Info given to patient**

Enrolment Info sheet ☐

Terms of Trade ☐