

ENROLMENT FORM

Address PO Box41, Warkworth 0941.
Phone Warkworth: 09 425 1199
Phone Snells Beach: 09 425 5055
EDI: kawaubay
E: reception@kawaubayhealth.co.nz



GP2GP : First Name - Kawau Bay Last Name - Health NZMC – 0000
WE DO NOT ACCEPT HARD COPY NOTES - ELECTRONIC FILES ONLY ACCEPTED

NHI (Office use only)

Legal Name *	(Title)	Given Name	Middle Name(s)	Family Name
Other Name(s) (eg. maiden name /preferred name)				
Birth Details *		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Male	Female	Gender Diverse (please state)	
Marital status Optional	Occupation*			
	Employer Name / Address *			

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 /NOK	Name	Relationship	Mobile (or other) Phone

Community Services Card	<input type="checkbox"/>	<input type="checkbox"/>	* Smoking status (if over 15) Never smoked <input type="checkbox"/> Current smoker <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Greater than 15months <input type="checkbox"/> less than 12 months <input type="checkbox"/> Would you like support to quit? Yes <input type="checkbox"/> No <input type="checkbox"/>
High User Health Card	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes	No	
	Yes	No	

Transfer of Records	<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, as I am only able to be enrolled at 1 practice at a time in NZ</i>	
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> Not applicable
	Previous Doctor and/or Practice Name	Address / Location

*Ethnicity Details Which ethnic group(s) do you belong to? Tick the space or spaces which apply to you.	<input type="radio"/> New Zealand European <input type="radio"/> Maori <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. <input type="text"/>	Primary Language Spoken: IWI <input type="checkbox"/> I authorise Kawau Bay Health to contact me via text message. <input type="checkbox"/> I authorise Kawau Bay Health to contact me via email. (non-secure)	Would you like to register for Manage My Health Patient Portal? You must have your own email address and be 16yrs or over. <input type="checkbox"/> Yes <input type="checkbox"/> No

*** 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 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 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 I have provided proof of my eligibility

Evidence sighted (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 on-going provider of general practice / GP / health care services.

I understand that by enrolling with Kawau Bay Health I will be included in the enrolled population of Waitemata PHO, and my name, address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers. Personal details and clinical notes may be shared with other Health Providers, or third-party requests as part of my healthcare e.g ACC, Insurance Company requests, Ministry of Health, WINZ etc.

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 or informed 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 agree with 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 health 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.

*Signatory Details	Signature	Day / Month / Year	<input type="checkbox"/>	<input type="checkbox"/>
			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 <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)		