comprehensive care

in association with waitemata pho

ENROLMENT FORM

Address 10 Percy Street, Warkworth. Auckland 0910 PO Box 285 Warkworth
P: 09 425 7358 **EDI: kowhaisu E:** general@kowhaisurgery.co.nz

GP2GP*: First name:* ***Kowhai*** *Surname:* ***Surgery*** *NZMC* ***0000***

Dr Suzanne Krueger Dr Sophie Lines
Dr Elspeth Dickson Dr Steve Maric

NHI *(Office use only)*

Legal Name	(Title)	Given Name	Middle Name(s)	Family Name
Other Name(s)		Preferred name/AKA	AKA	Maiden name/AKA
Birth Details				
		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender	☐ Male	☐ Female	☐ Gender diverse (please state)	
Employment		Occupation	Address of Employer	

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	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number
High User Health Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number

Transfer of Records	*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*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ 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***	New Zealand European Maori Samoan Cook Island Maori Tongan Niuean Chinese Indian Other (such as Dutch, Japanese, Tokelauan). Please state	**Primary Language Spoken:** Smoking status: Never smoked ☐ Ex-smoker ☐ Vape ☐ > 15months☐ < 12 months ☐ Current smoker ☐ Would you like support to quit? Yes ☐ No ☐ ☐ I authorise Kowhai Surgery to contact me via text message ☐ I authorise Kowhai Surgery to contact me via email

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, 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 below, you will need to bring in your passport so that the visa can be sighted and copied for verification of eligibility.

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	☐

Circle the form of proof provided for eligibility :	**Passport / Visa / Birth Certificate**

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 Kowhai Surgery 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 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
	Basis of authority (e.g. parent of a child under 16 years of age)		