| FEILDING HEALTH CARE Hauora Tangata | **ENROLMENT FORM** | Feilding Health Care<br>7 Duke Street<br>Feilding 4702<br>Ph (06) 323 9696<br>Fax (06) 323 9690 | NHI:<br><br>(*Office use only)* |
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|---|---|---|---|---|
| **Legal Name** (Title) | Given Name | Middle Name(s) | Family Name | |
| **Other Name** | Other Name | Other Given Name(s) | Other Family Name (eg. maiden name) | |
| **Preferred Name** | Preferred Name | Preferred Other Given Name(s) | Preferred Other Family Name | |
| **Birth Details** | Day / Month / Year of Birth | Place of Birth | Country of birth | |
| **Gender** | ☐ Male ☐ Female ☐ Other | Reason for "Other" status | *Practice Specific Field* | |

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| **Usual Residential Address** | House (or RAPID) Number and Street Name | Suburb | Town / City and Postcode |
| **Postal Address** (if different from above) | House Number and Street Name or PO Box Number | Suburb | Town / City and Postcode |

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| **Contact Details** | Mobile Phone | Home Phone | Email Address |
| **Emergency Contact** | Name | Relationship | Mobile (or other) Phone |

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| **Community Services Card number:** | **Expiry:** |
| **High User Card Number:** | **Expiry:** |

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| **Ethnicity Details**<br>Which ethnic group(s) do you belong to?<br>***Tick the space or spaces which apply to you*** | ○ New Zealand European<br>○ Maori<br>○ Samoan<br>○ Cook Island Maori<br>○ Tongan | ○ Niuen<br>○ Chinese<br>○ Indian<br>○ Other (such as Dutch, Japanese, Tokelauan). Please state | **Iwi:**<br><br>**Main language spoken at home:** |

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| **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.* | | |
| | ☐ Yes, please request transfer of my records | ☐ No transfer | ☐ Not applicable |
| | TO: EDI: **feilding** | Doctor: | NZMC: |
| | Previous Doctor and/or Practice Name | Address / Location | |

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| **Smoking status** | *Please tick your current smoking status:* | | |
| | ☐ Current Smoker | ☐ Trying to Quit | ☐ Passive Smoker |
| | ☐ Ex Smoker | ☐ Ex Smoker > 12 months | ☐ Never smoked |
| *The best advice we can give you for your health is to be smoke-free. We can help, would you like a referral to a quit smoking coach to help you on your journey to wellness and a smoke-free future?* Yes ☐ No ☐ | | | |

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| **Patient Survey** | *From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous*<br>☐ No, I do not wish to participate in the Patient Survey |

# My declaration of entitlement and eligibility

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| **I intend to use this practice** as my regular and on-going provider of general practice / GP / health care services. | ☐ |
| **I am entitled to enrol** because I am residing permanently in New Zealand.<br>*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:

| | | |
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| 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 entitlement criteria applies to you (b–j) below:

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| 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 and 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 | ☐ |

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| **I confirm** that, if requested, I can provide proof of my eligibility | ☐ |

# My agreement to the enrolment process

**NB. Parent or Caregiver to sign if you are under 16 years**

**I understand** that by enrolling with this practice I will be included in the enrolled population of the Primary Health Organisation (PHO) this practice is contracted to, 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 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.

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| **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.***

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| **Authority Details**<br>*(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) | | |

Evidence sighted Y / N _____ *(Office use only)*