



ENROLMENT FORM

Te Ngae Medical Centre
 Redwood Centre
 5 Tarawera Road, Lynmore, Rotorua
 PO box 7004
 Te Ngae 3042
 Ph 073456627 fax 073457795

EDI: tengaemc

NHI (Office use only)

Legal Name				
	(Title)	Given Name	Other Given 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	Town of Birth	Country 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	Town / City and Postcode
Postal Address <small>(if different from above)</small>	House Number and Street Name or PO Box Number	Suburb	Town / City and Postcode

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

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

Ethnicity Details: Which ethnic group(s) do you belong to?	Please circle Doctor you wish to be enrolled with	Please answer questions listed below:																				
<table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 80%;">New Zealand European</td><td style="width: 20%;"></td></tr> <tr><td>Maori</td><td></td></tr> <tr><td><i>Iwi/Hapu:</i></td><td></td></tr> <tr><td>Samoan</td><td></td></tr> <tr><td>Cook Island Maori</td><td></td></tr> <tr><td>Tongan</td><td></td></tr> <tr><td>Niuen</td><td></td></tr> <tr><td>Chinese</td><td></td></tr> <tr><td>Indian</td><td></td></tr> <tr><td>Other (such as Dutch, Japanese, Tokelauan). Please state:</td><td></td></tr> </table>	New Zealand European		Maori		<i>Iwi/Hapu:</i>		Samoan		Cook Island Maori		Tongan		Niuen		Chinese		Indian		Other (such as Dutch, Japanese, Tokelauan). Please state:		Dr Ron Vail Dr Robyn Parker Dr Sarah Dalziel Dr Sally Hoskins Dr Andrew McMenamin Dr Neil Poskitt	Smoking Status; please circle one Current smoker Never smoked Ex less than 12 months Ex more than 12 months I give permission for TNMC to send my results via email YES <input type="checkbox"/> NO <input type="checkbox"/> I give permission for TNMC to send my results via text YES <input type="checkbox"/> NO <input type="checkbox"/>
New Zealand European																						
Maori																						
<i>Iwi/Hapu:</i>																						
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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.</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

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 entitlement 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 and 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 will provide proof of my eligibility for Te Ngae Medical Centre to photocopy and hold on file

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 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 understand that the Practice participates in a national survey about people's health care experience and how their overall 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	<input type="checkbox"/>	<input type="checkbox"/>
	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
	Authority Details Basis of authority (e.g. parent of a child under 16 years of age)		