ENROLMENT FORM

Te Atatu Health
544b Te Atatu Rd
Te Atatu Peninsula, Auckland 0610
EDI: tahealth

Areas in blue are essential, areas in white are optional

NHI *(Office use only)*

Title	First Name	Middle Name (s)	Surname
☐ Male ☐ Female ☐ Gender diverse (please state)		Alias / Preferred Name	Maiden Name
Date of Birth dd / mm / yyyy	Country of Birth	City/Town of birth	Occupation

Ethnicity Details

Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you

☐ New Zealand European ☐ Niuean ☐ Thai
☐ Maori ☐ Cook Island Maori ☐ Filipino
☐ Samoan ☐ Fijian ☐ Other: Please state _____
☐ Tongan ☐ Chinese

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

Your Contact Details please provide us with as much detail as you can

Mobile Number	Home Phone number	Email
		Would you like to register for the online patient portal MyIndici? ☐ Yes ☐ No

Person to contact in case of Emergency	Name:	
Relationship	Mobile or other number	Other contact

Do you have a Community Services Card ?	☐ No	☐ Yes	**Do you have a High User Health Card ?**	☐ No	☐ Yes
Do you have Southern Cross Insurance?	☐ No	☐ Yes	**Do you smoke?** ☐ Ex smoker	☐ No	☐ Yes
Smoking is bad for your health			**Do you need help to quit smoking?**	☐ No	☐ Yes

Transfer of Records

In order to get the best care possible, we recommend you give permission for us to obtain your records from your last Doctor. Either way you will automatically be removed from their register.

Last Practice Name	Doctor	☐ Yes, please request transfer of my records ☐ No, I decline for my records to be requested

comprehensive care

MY Declaration of entitlement and eligibility

1	**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*	☐ No	☐ Yes

2 a.	**I AM a New Zealand Citizen**	☐ No	☐ Yes

If NO - tick the box that applies to you

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	☐

3	**I confirm** that, if requested, I can provide proof of my eligibility	☐ Yes	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 ongoing provider of general practice / GP / health care services.

I understand that by enrolling with Te Atatu Health I will be included in the enrolled population of Comprehensive Care, 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.

I agree to make payment for any services within 7 days. Failure to do so may result in the involvement of a debt collection agency, and a 20% fee may be added to the total amount due.

Signatory Details

Signature	Today's Date dd / mm / yyyy	☐ ☐ **Signing for:** Self Authority

IF as Authority

(where signatory is not the enrolling person) ***An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.***

Your Full Name	Relationship	Why is Authority required?	Contact Phone