



ENROLMENT FORM

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

Areas in blue are essential, areas in white are optional

NHI (Office use only)

Title	First Name	Middle Name (s)	Surname
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> 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? <i>Tick the space or spaces which apply to you</i>	<input type="checkbox"/> New Zealand European	<input type="checkbox"/> Chinese
	<input type="checkbox"/> Maori	<input type="checkbox"/> Thai
	<input type="checkbox"/> Samoan	<input type="checkbox"/> Filipino
	<input type="checkbox"/> Cook Island Maori	<input type="checkbox"/> Other: Please state
	<input type="checkbox"/> Tongan	_____
	<input type="checkbox"/> Niuean	

Usual Residential Address

House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
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Postal Address (if different from above)

House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode
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Your Contact Details please provide us with as much detail as you can

Mobile Number	Home Phone number	Email
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Person to contact in case of Emergency

Name:		
Relationship	Mobile or other number	Other contact

Do you have a Community Services Card ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Card Number	Expiry dd/mm/yyyy
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Do you have a High User Health Card ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Card Number	Expiry dd/mm/yyyy
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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	<input type="checkbox"/> Yes, please request transfer of my records
		<input type="checkbox"/> No, I decline for my records to be requested

MY Declaration of entitlement and eligibility

1	I AM Residing permanently in New Zealand. <i>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>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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2 a.	I AM a New Zealand Citizen	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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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)	<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"/>

3	I confirm that, if requested, I can provide proof of my eligibility	<input type="checkbox"/> Yes	Evidence sighted (Office use only)
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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.

Signatory Details

Signature	Today's Date dd / mm / yyyy	<input type="checkbox"/> Self <input type="checkbox"/> Authority Signing for:
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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
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