PATIENT ENROLMENT FORM

BLOCKHOUSE BAY ProCARE

PLEASE SEND NOTES VIA GP2GP

☐ Dr Tina Lavulo #59395
☐ Dr Mary Kanjirathinkal #37727
☐ Dr Asif Rahman #33252

EDI Number	Address	Phone	Fax	NHI (Office use only)
PACIHORI	297 Blockhouse Bay Rd, BHB	09 828 8421	09 828 8762	

Legal Name
Title _____ Given name _____ Other given name(s) _____ Family name _____

Other Name(s) Also known as *(e.g. maiden name)*
Please tick the name you prefer to be known as
Also known as _____ Maiden Name _____

Birth Details
Day/Month/Year __/__/____ Place of Birth _____ Country of birth _____

Gender
☐ Male ☐ Female ☐ Gender diverse (please state) Occupation _____

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 Location _____ Town / City and Postcode _____

Contact Details
Mobile phone _____ Home phone _____ Email address _____

Emergency Contact
Name _____ Relationship _____ Mobile or other phone _____

Community Service Card
☐ Yes ☐ No Exp: Day/Month/Year __/__/____ Card number _____

High User Health Card
☐ Yes ☐ No Exp: Day/Month/Year __/__/____ Card number _____

Do you smoke?
☐ Yes ___ per day. ☐ No (ex-smoker) more than 12 mths. ☐ No (ex-smoker) less than 12 mths. ☐ Never Smoked.
Smoking is bad for your health, would you like help to quit today? ☐ Yes ☐ No

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 my records Signature _____ Day/Month/Year __/__/____ ☐ N/A
Previous Doctor or Practice Name / Address _____ Phone _____ Fax _____

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
☐ Fijian
☐ Chinese
☐ Indian
☐ Other *(such as Dutch, Japanese, Tokelauan). Please state* _____

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.

Patient Survey Contact Details:
☐ As provided above, or
☐ I do not wish to participate in the Patient Survey

How did you hear about the Fono?
☐ Word of mouth / Family
☐ Internet / Website
☐ Signage / building location
☐ Referral from another service
☐ Referral from community group
☐ Event
☐ Radio
☐ Print Magazine
☐ TV
☐ Newspaper
☐ E-Newsletter
☐ Social Media
☐ Other: Please specify _____

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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 eligibility 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)

☐ 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

☐ **I confirm that, if requested, I can provide proof of my eligibility** _____
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 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 with the Primary Health Organisation (PHO) this practice belongs 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.

The Fono complies with the Privacy Act 1993 and the Health Information Privacy Code 1994 when collecting, using and managing personal information. I have been provided with a copy of the Code of Rights and are entitled to make a complaint at any time.

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)

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