



# ProCARE PATIENT ENROLMENT FORM

**PLEASE SEND NOTES VIA GP2GP**

- DR LUISA FONUA-FAEAMANI # 59395
- DR Natalie Hopoi # 36303
- DR Nitin Darbarwar # 50882
- DR Catherine Latu # 33105

<b>THE FONO HENDERSON</b>				
<b>PASIFIKA</b>	<b>411 Great North Road, Henderson 0610</b>	<b>09 837 1780</b>	<b>09 837 1276</b>	
EDI Number	Address	Phone Number	Fax Number	NHI (Office use only)

<b>Legal Name</b>	(Title)	Given Name	Other Given Name(s)	Family Name
<b>Other Name(s) Also known as</b> (e.g. maiden name) Please tick the name you prefer to be known as		Also known as		Maiden Name
<b>Birth Details</b>		Day / Month / Year of Birth	Place of Birth	Country of birth
<b>Gender</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)	Occupation

<b>Usual Residential Address</b>	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
<b>Postal Address</b> (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

<b>Contact Details</b>	Mobile Phone	Home Phone	Email Address
<b>Emergency Contact</b>	Name	Relationship	Mobile (or other) Phone

<b>Community Services Card</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number
<b>High User Health Card</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number

<b>Do you smoke?</b>	Yes <input type="checkbox"/> ___ per day No (ex-smoker) more than 12 months <input type="checkbox"/> No (ex-smoker) less than 12 months <input type="checkbox"/> <b>Never Smoked</b> <input type="checkbox"/>		
Smoking is bad for your health, would you like help to quit today? Yes <input type="checkbox"/> No <input type="checkbox"/>			

<b>Transfer of Records</b>	<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 my records		Signature:	Date:
Previous Doctor or Practice Name / Address		Phone:	Fax:

<b>Ethnicity Details</b> Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	<input type="radio"/> New Zealand European <input type="radio"/> Maori <input type="radio"/> Samoan <input type="radio"/> Cook Island Maori <input type="radio"/> Tongan <input type="radio"/> Niuean <input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Patient Survey</b> <i>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.</i>  <b>Patient Survey Contact Details:</b> As provided above <input type="checkbox"/> (or) <input type="checkbox"/> I do not wish to participate in the Patient Survey
<b>**How did you hear about the Fono?*</b>		g. Advertising (tick)
<input type="checkbox"/> a. Word of mouth / Family <input type="checkbox"/> b. Internet / Website <input type="checkbox"/> c. Signage / building location <input type="checkbox"/> d. Referral from another service <input type="checkbox"/> e. Referral from community group <input type="checkbox"/> f. Event		<input type="checkbox"/> Radio <input type="checkbox"/> Print Magazine <input type="checkbox"/> TV <input type="checkbox"/> Newspaper <input type="checkbox"/> E-Newsletter <input type="checkbox"/> Other: Please specify _____

## 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>b</b>	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	<input type="checkbox"/>
<b>c</b>	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"/>
<b>d</b>	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"/>
<b>e</b>	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
<b>f</b>	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"/>
<b>g</b>	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 <b>OR</b> in the control of the Chief Executive of the Ministry of Social Development	<input type="checkbox"/>
<b>h</b>	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"/>
<b>i</b>	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
<b>j</b>	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, 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.

**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.

<b>Signatory Details</b>		/ /	<input type="checkbox"/>	<input type="checkbox"/>
	Signature	Day / Month / Year	Self-Signing	Authority
<b>An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.</b>				
<b>Authority Details</b> <i>(where signatory is not the enrolling person)</i>	Full Name	Relationship	Contact Phone	
	Basis of authority (e.g. parent of a child under 16 years of age)			