Te Kauwhata Health Centre
PATIENT ENROLMENT FORM

Each person 16 years or over to complete and sign own form

itsmyhealth™ Midlands Health Network

***Must be completed** NHI: (Office Use Only)*

1. Personal Details:

Title: **Family Name:*** **First Name/s:***

Preferred Name: **Other name/s known by and/or Maiden name:**

Date of Birth:* **Gender:*** Please Tick ✓ **Account holder:** Please Tick ✓

M F Y N

2. Contact Details:

Physical Address:*

Unit/House No: **Street:** **Suburb:**

Town/City: **Postcode:**

Home Phone: **Work Phone:** **Mobile Phone:**

0 0 0

Postal Address: (If different from Physical Address)

PO Box/Unit/ House No: **Street:** **Suburb/Rural Delivery:**

Town/City: **Postcode:**

3. Ethnicity*:

WHICH ETHNIC GROUP DO YOU BELONG TO? (YOU MAY SELECT UP TO THREE ETHNICITIES):

NZ European/Pakeha	11	Tokelauan	35	Not Stated	99
Maori (please state iwi)	21	African	53	Declined	98
Samoan	31	Other Pacific	37	Latin American/Hispanic	52
Cook Island Maori	32	Middle Eastern	51	Fijian	36
Tongan	33	South East Asian	41	Other European	12
Niuean	34	Other Asian	44		
Chinese	42				
Indian	43				
Other Ethnicity (please state)	61				

4. Residential Status:

Country of Birth:*
If New Zealand is your country of birth, go to Q5

If you are not born in NZ are you a NZ resident? Yes ☐ No ☐

Are you on a working Visa? Yes ☐ No ☐

Are you a refugee: Yes ☐ No ☐

Visa/Permit Sighted: (Office Use Only) Yes ☐ No ☐

5. Next of Kin/Emergency Contact Details:

Title: **Family Name :**

First Name/s: **Relationship:**

Physical Address:

Unit/House No: **Street:** **Suburb:**

Town/City: **Postcode:**

Day Phone: 0

Mobile Phone: 0

6. Community Health Details:

Community Services Card No: 0 0 0 0 0

Expiry Date: / / Sighted: (Office Use Only) Yes ☐ No ☐

High User Health Card No:

Expiry Date: / / Sighted: (Office Use Only) Yes ☐ No ☐

7. Employer:

Name:

Address:

Town/City: **Phone:**

Occupation :

8. Smoking Status:

Smoking status is an important factor influencing health. Please tick the space that applies for those aged 15 and over:

☐ Never smoked ☐ In the past smoked daily for more than a year but no longer smoke ☐ Currently a smoker

If you are currently a smoker – would you like to discuss quitting smoking – YES/NO

SIGNED AUTHORITY:

I intend to use Te Kauwhata Health Centre as my regular and ongoing provider of general practice / GP / First Level primary health care services.

I am entitled to enrol because I am residing permanently in New Zealand[1] and meet one of the following eligibility criteria:

		Please circle one
a)	I am a New Zealand citizen **OR**	Yes / No
b)	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010	Yes / No
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	Yes / No
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)	Yes / No
e)	I am an interim visa holder who was eligible immediately before my interim visa started	Yes / No
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	Yes / No
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	Yes / No
h)	I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder	Yes / No
i)	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)	Yes / No
j)	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	Yes / No
k)	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund.	Yes / No

I confirm that, if requested, I can provide proof of my eligibility.

MY AGREEMENT TO THE ENROLMENT PROCESS:

(NB Parent or caregiver to sign if you are under 16 years)

I choose to enrol with this practice as my regular and on going provider of general practice / GP / First Level primary health care services.

I understand that by enrolling with this practice I will be enrolled with the Midlands Regional Health Network Charitable Trust, and my name address and other identification details will be included on both the Practice and the PHO Enrolment Register.

I understand that if I visit another 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 with the Midlands Regional Health Network Charitable Trust, and their contact details.

I have read and I agree with the Health Information Privacy Statement.

I agree to inform the practice of any changes in my eligibility.

	/ / Day Month Year
SIGNATURE*	**DATE***

OR signed by AUTHORITY[2]

Full Name of Authority:	Contact Phone Number:	Relationship:
Address:	Signature of Authority:	/ / Day Month Year
Detail the basis of authority (e.g. parent of a child under 16):		

[1] The definition of residing in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months.

[2] An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

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Midlands Health Network

TE KAUWHATA HEALTH CENTRE

REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

Each person 16 years or over to complete and sign own form

In order to receive the best care possible, I agree to Te Kauwhata Health Centre obtaining my medical records from my previous doctor. I also understand that I will be removed from their practice register.

To:
Address:

Please transfer the medical records for the following people to Te Kauwhata Health Centre

Family Name	Given Names	DOB or NHI

GP2GP: Dr Robin Baird – 62944

EDI: tekauwhc

Signed: _____ **Date:** _____