

	<h1>ENROLMENT FORM</h1> <p>Fred Thomas - 2 Fred Thomas Drive & Hauraki Corner - 308 Lake Road Takapuna, Auckland 0622</p>	
	<p>Ph: 09 972 9020 EDI: fthealth Fax: 09 489 5597 Email: info@fthealth.co.nz</p>	

Please send GP2GP notes to NZMC: 00000 Practice Mailbox/EDI: fthealth First name: Fred Last name: Thomas	NHI (Office use only)
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Legal Name *	(Title)	Given Name	Middle Name(s)	Family Name
Other Name(s) (eg. maiden name /preferred name)				
Birth Details *	Day / Month / Year of Birth		Place of Birth	Country of birth
Gender *	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)	
Occupation				Employer Name & Address

Usual Residential Address *	House (or RAPID) Number and Street Name	Suburb	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

*Contact Details	Mobile Phone	Home Phone	Email Address
*Emergency Contact /NOK	Name	Relationship	Mobile (or other) Phone

Community Services Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High User Health Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patients 16 years and over: Would you like us to sign you up for our Patient Portal – Manage My Health? This website/app gives you secure access to your individual health information. It enables you to make appointments, access your lab results, order prescriptions, message your doctor and update your personal details online.					<input type="checkbox"/> Yes

Transfer of Records	<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, as I am only able to be enrolled at 1 practice at a time in NZ</i>		
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor and/or Practice Name		Address / Location

*Ethnicity Details Which ethnic group(s) do you belong to? Tick the space or spaces which apply to you:	<input type="radio"/> NZ European <input type="radio"/> NZ Maori <input type="radio"/> Chinese <input type="radio"/> Southeast Asian <input type="radio"/> Indian <input type="radio"/> Latin American <input type="radio"/> Samoan <input type="radio"/> Other European, Asian or Pacific – please state:	Primary Language Spoken: IWI: * Smoking status (15 years and over) <input type="checkbox"/> Never smoked <input type="checkbox"/> Ex-smoker - <input type="checkbox"/> Greater than 15months <input type="checkbox"/> less than 12 months <input type="checkbox"/> Current smoker <input type="checkbox"/> Would you like support to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No
	I authorise The Doctors to contact me via text message Yes / No	
	I authorise The Doctors to contact me via email (non-secure) Yes / No	

* My declaration of entitlement and eligibility

1. I am entitled to enrol because 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"/>
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I am eligible to enrol because:

a	I am a New Zealand citizen <i>(If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below)</i>	<input type="checkbox"/>
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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)	<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"/>

I confirm that I have provided proof of my eligibility	<input type="checkbox"/>	Evidence sighted <i>(Office use only)</i>
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* My agreement to the enrolment process

NB. Parent or Caregiver to sign if patient enrolling is 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 The Doctors Fred Thomas & Hauraki Corner, I will be included in the enrolled population of Comprehensive Care PHO, and my name, address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers. Personal details and clinical notes may be shared with other Health Providers, or third party requests as part of my healthcare e.g ACC, Insurance Company requests, Ministry of Health, WINZ etc.

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 or informed 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	Day / Month / Year	<input type="checkbox"/>	<input type="checkbox"/>
			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	Full Name	Relationship	Contact Phone
<i>(where signatory is not the enrolling person)</i>	Basis of authority (e.g. parent of a child under 16 years of age)		