

316 Ti Rakau Drive  
 Burswood  
 Auckland 2013

**Monday – Friday**  
**8am – 6pm**  
**Ph: 09 273 8980**
**Email:** info@tr.thedoctors.co.nz  
**EDI:** tirakauc

<b>Title</b>	<b>Legal Given Name</b>	<b>Middle Name(s)</b>		<b>Family Name</b>		
<b>Preferred Name</b>	<b>Maiden Name</b>	<b>Assigned Sex at Birth:</b>	<b>Please Tick</b>	<b>Male</b>	<b>Female</b>	
<b>Date of Birth</b> / /	<b>Place of Birth:</b> <b>Country of Birth:</b>	<b>Gender:</b>	<b>Please Tick</b>	<b>Male</b>	<b>Female</b>	<b>Another Gender:</b>
<b>Occupation</b>	<b>Employer Name &amp; Address</b>					

<b>Usual Residential Address</b>	<b>House Number &amp; Street Name</b>	<b>Suburb</b>	<b>Town / City</b>	<b>Postcode</b>	
<b>Postal Address</b> <i>If different from above</i>	<b>Number/Street Name/PO Box</b>	<b>Suburb/Rural Delivery</b>	<b>Town / City</b>	<b>Postcode</b>	
<b>Mobile Phone</b>	<b>Home Phone</b>	<b>Email Address</b>			
<b>Emergency Contact Person Full Name</b>		<b>Relationship</b>	<b>Mobile (or other) Phone</b>		
<b>I authorise The Doctors to contact me to receive test results, notice of recalls, other info via text message</b>	<b>Yes</b>	<b>No</b>	<b>I authorise The Doctors to contact me to receive test results, notice of recalls, other information via email (non-secure)</b>	<b>Yes</b>	<b>No</b>

<b>Ethnicity Details</b> <i>Tick all groups that apply to you</i>		<b>Primary Language Spoken</b>					
<input type="checkbox"/>	NZ European	<input type="checkbox"/>	Latin American	<b>IWI</b>			
<input type="checkbox"/>	NZ Maori	<input type="checkbox"/>	Samoan	<b>Smoking Status (15 years and over, please state below)</b>			
<input type="checkbox"/>	Chinese	<input type="checkbox"/>	Tongan	<input type="checkbox"/>	Never Smoked	<input type="checkbox"/>	Current Smoker
<input type="checkbox"/>	Southeast Asian	<input type="checkbox"/>	Other (please state)	<input type="checkbox"/>	Ex-smoker, >15 months	<input type="checkbox"/>	Ex-smoker < 12 months
<input type="checkbox"/>	Indian			Would you like support to quit?			<b>Yes</b>

<b>Community Services Card</b>	<b>Yes</b>	<b>No</b>	<b>High User Health Card</b>	<b>Yes</b>	<b>No</b>
<b>Registration to Online Patient Portal?</b> <i>For 16+ year olds we have an online patient portal that gives you access to your health information, test results and you can book appointments and order prescriptions 24/7.</i>				<b>Yes</b>	<b>No</b>
<b>If yes, state the email address for patient portal set up</b>					

<b>Transfer of Records</b>	<i>In order to get the best health care possible, I agree to this 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 one practice at a time in New Zealand.</i>					
	<input type="checkbox"/>	<b>Yes, request transfer</b>	<input type="checkbox"/>	<b>No, do not transfer</b>	<input type="checkbox"/>	<b>Not applicable</b>
	<b>Previous Doctor and/or Practice Name</b>			<b>Old Practice Address / Location</b>		

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 a resident in NZ for at least 183 days in the next 12 months</i>	Tick
2.	I am eligible to enrol because I am a New Zealand Citizen <i>(If yes, tick box and go to I confirm that, if requested, I can provide proof of my eligibility below)</i>	
3.	If you are <b>not</b> a New Zealand, please tick which eligibility criteria applies to you (a-i) below:	
	a) I hold a resident visa or permanent resident visa (or a residence permit if issued before December 2010)	
	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	
	c) 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)	
	d) I am an interim visa holder who was eligible immediately before my interim visa started	
	e) 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	
	f) 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-e above OR in the control of the Chief Executive of the Ministry of Social Development	
	g) 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)	
	h) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	
	i) I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a NZ University under the Commonwealth Scholarship and Fellowship Fund	

My Proof of Eligibility					
<i>The National Enrolment Service (NES) now requires all new patients who enrol with this practice to provide us evidence of your Identity and Eligibility to Enrol. <b>NB: Names and birthdates on all documents must match details on this Enrolment Form.</b> Please bring with you to reception. These acceptable identification documents to complete enrolment:</i>					
<b>New Zealand Citizens or Residents</b> <i>Tick which ID provided</i>			<b>Australian Citizens</b> <i>Tick which ID provided</i>		
<b>Provide <u>one</u> of these:</b>			<b>Provide <u>one</u> of these:</b>		<b><u>Plus one</u> of these:</b>
	NZ Passport			Passport	NZ Bank statement
	NZ Driver's Licence			NZ 18+Card	
	NZ school or tertiary ID card			Overseas Passport with Permanent Resident Visa	NZ Employment contract (excluding fixed-term /casual)
				NZ Driver's Licence	
<b>Other or Non-New Zealand Citizens</b> <i>Tick if provided</i>				NZ school or tertiary ID card	
	Overseas Passport with 2yr+Work Visa (2 years from date of entry to NZ)				
I confirm that I have provided <b>proof of my eligibility</b>			Tick	Evidence sighted <i>(Office Use Only)</i>	Sign

My Agreement to the Enrolment Process
<p>I intend to use this practice as my regular and on-going provider of general practice/GP/health care services.</p> <p>I understand that by enrolling with <b>The Doctors Ti Rakau</b> I will be included in the enrolled population of <b>ProCare Health Ltd</b> and my name address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers.</p> <p>I understand that if I visit another health care provider where I am not enrolled I may be charged a higher fee.</p> <p>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>ProCare Health Ltd, Ph: 09 377 7827, www.procre.co.nz</i></p> <p>I have read and I agree with the <b>Health Information and Privacy Statement</b>. The information I have provided on this 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.</p>

**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.

**I agree** to the Practice collecting, using and sharing my personal and health information as outlined in the **Health Information and Privacy Statement** and the [Green Cross Health Customer Privacy Policy](https://www.greencrosshealth.co.nz/privacy-policy) (<https://www.greencrosshealth.co.nz/privacy-policy>).

*I agree to pay all accounts promptly, including any fees that may accrue. I understand that the terms of agreement state that the account must be paid on the day of consultation and **if the account is not paid on the day of consultation, the account will be subject to a \$15 administration fee.** I understand that unpaid accounts will be referred to a debt collection agency and any cost incurred in the recovery will be my responsibility*

*Parent or Caregiver to sign if the patient enrolling is under 16 years including completion of Authority Details.*

<b>Signatory Details</b>	<b>Signature</b>	<b>Date</b> / /		<b>Self Signing</b>		<b>Authority</b>
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*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>Authority Details</b> <i>(where signatory is not the enrolling person)</i>	<b>Full Name</b>	<b>Relationship</b>
	<b>Contact Phone</b>	<b>Legal basis of authority</b> (e.g. parent of child under 16 years)