

PIHANGA HEALTH

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PATIENT ENROLMENT FORM

Each Person 16 years or over to complete and sign own form
Each enrolled patient must have their own enrolment form

***Must be completed**

NHI: (Office Use Only)*

1. Personal Details:

Title:	Family Name:	First Name/s:*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Preferred Name:	Other name/s known by and/or Maiden name:	
<input type="text"/>	<input type="text"/>	
Date of Birth:*	Gender:*	Account holder: Please Tick ✓
<input type="text"/>	M/ F <input type="text"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>

2. Contact Details:

Physical Address:*

Unit/House No:	Street:	Suburb:			
<input type="text"/>	<input type="text"/>	<input type="text"/>			
Town/City:	Postcode:				
<input type="text"/>	<input type="text"/>				
Home Phone:	Work Phone:	Mobile Phone:			
<input type="text"/>	<input type="text"/>	<input type="text"/>			
Email Address: <input type="text"/>					
Postal Address: (If different from Physical Address)					
PO Box/Unit/ House No:	Street:	Suburb/Rural Delivery:			
<input type="text"/>	<input type="text"/>	<input type="text"/>			
Town/City:	Postcode:				
<input type="text"/>	<input type="text"/>				
Preferred Contact Methods: Please Tick ✓		Consent to use text messaging:			
Secure Email <input type="checkbox"/>	Text <input type="checkbox"/>	Landline <input type="checkbox"/>	Cell Phone <input type="checkbox"/>	Post <input type="checkbox"/>	Yes / No Please Circle One

3. Ethnicity*:

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

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

4. Residential Status: A PASSPORT OR BIRTH CERTIFICATE MUST BE PROVIDED ON ENROLMENT

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 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: Postal Code:

Day Phone: Mobile Phone:

6. Community Health Details:

Community Services Card No: 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

Signed Authority:

I intend to use Pihanga Health 2007 Ltd 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 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.
Reception - eligibility proof sighted -copy taken / patient re enrolled and known to clinic Initial _____

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 / First Level primary health care services.

I understand that by enrolling with **Pihanga Health 2007 Ltd** I will be included in the enrolled population that the Primary Health Organisation (PHO) this practice belongs to , and my name address and other identification details will be included on 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 2020.

I understand that the Practice participates in the 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 or opt out of the survey by informing the Practice. The survey provides important information that is used to improve the health services.

I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

	/ / Day Month Year
SIGNATURE	DATE

OR signed by AUTHORITY2

Full Name of Authority:	Contact Phone Number:	Relationship:
Address:	Signature of Authority:	/ / Day Month Year

- 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.