



in association with
waitemata
pho

ENROLMENT FORM

Address 10 Percy Street, Warkworth. Auckland 0910 PO Box 285 Warkworth
P: 09 425 7358 F: 09 425 9932
EDl: kowhaisu E: kowhaisurgery@xtra.co.nz

GP2GP: Kowhai Surgery NZMC 0000

Dr Suzanne Krueger
Dr Elspeth Dickson

Dr Sophie Lines
Dr Steve Maric

NHI (Office use only)

Legal Name	(Title)	Given Name	Middle Name(s)	Family Name
Other Name(s)	Preferred name/AKA		AKA	Maiden name/AKA
Birth Details	Day / Month / Year of Birth		Place of Birth	Country of birth
Gender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Male	Female	Gender diverse (please state)	
Employment	Occupation		Address of Employer	
Usual Residential Address	House (or RAPID) Number and Street Name		Suburb/Rural Location	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"/>	<input type="checkbox"/>	Day / Month / Year of Expiry	Card Number
	Yes	No		
High User Health Card	<input type="checkbox"/>	<input type="checkbox"/>	Day / Month / Year of Expiry	Card Number
	Yes	No		
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? <i>Tick the space or spaces which apply to you</i>	New Zealand European Maori Samoan Cook Island Maori Tongan Niuean Chinese Indian Other (such as Dutch, Japanese, Tokelauan). Please state		Primary Language Spoken:	
			IWI	
			Smoking status (if over 15) 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? Yes <input type="checkbox"/> No <input type="checkbox"/>	
			<input type="checkbox"/> I authorise Kowhai Surgery to contact me via text message	
			<input type="checkbox"/> I authorise Kowhai Surgery to contact me via email	

My declaration of entitlement and eligibility

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, 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 below, you will need to bring in your passport so that the visa can be sighted and copied for verification of eligibility.

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"/>

Circle the form of proof provided for eligibility :	<input type="checkbox"/> Passport / Visa / Birth Certificate
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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 Kowhai Surgery I will be included in the enrolled population of Waitemata 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 agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

Signatory Details		<input type="checkbox"/>	<input type="checkbox"/>
Signature	Day / Month / Year	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		
<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)	