



ENROLMENT FORM

Address 10 Percy Street, Warkworth. Auckland 0910 PO Box 285 Warkworth
P: 09 425 7358 **EDI:** kowhaisu **E:** general@kowhaisurgery.co.nz

GP2GP: First name: Kowhai Surname: Surgery NZMC 0000

Dr Susanne Krueger Dr Sophie Lines Dr Nicolas Thorburn
 Dr Elspeth Dickson Dr Steve Maric **Dr Daniela Fernandes**

NHI (Office use only)

Legal Name	(Title)	Given Name	Middle Name(s)	Family Name
	Other Name(s)		Preferred name/AKA	AKA
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)
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

Contact Details	Mobile Phone	Home Phone	Email Address
	Emergency Contact /NOK	Name	Relationship

Community Services Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number
	High User Health Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry

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	Primary Language Spoken:
	Maori	
	Samoan	
Cook Island Maori	Smoking status: Never smoked <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Vape <input type="checkbox"/>	
Tongan	> 15months <input type="checkbox"/> < 12 months <input type="checkbox"/> Current smoker <input type="checkbox"/>	
Niuean	Would you like support to quit? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Chinese	<input type="checkbox"/> I authorise Kowhai Surgery to contact me via text message	
Indian	<input type="checkbox"/> I authorise Kowhai Surgery to contact me via email	
Other (such as Dutch, Japanese, Tokelauan). Please state		

Primary Health Services Provider Enrolment Form - Version June 2019

My declaration of entitlement and eligibility

I am entitled to enrol because I am residing permanently in New Zealand. <small>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</small>	<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 :	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			
<small>(where signatory is not the enrolling person)</small>	Full Name	Relationship	Contact Phone
Basis of authority (e.g. parent of a child under 16 years of age)			