



**PATIENT ENROLMENT FORM**  
 Kowhai Surgery 10 Percy Street P.O Box 285 Warkworth 0910  
 P: 094257358 E:general@kowhaisurgery.co.nz EDI: KOWHAISU



|   |  |                               |
|---|--|-------------------------------|
| <b>Fields shaded in are compulsory.</b> | <b>EDI Number: KOWHAISU</b>  | <b>NHI (Office use only):</b> |
|   | <b>GP2GP: Kowhai Surgery NZMC No: 0000</b><br><b>GP Providers:</b><br>Dr Susanne Krueger/ Dr Sophie Lines / Dr Nicolas Thorburn<br>Dr Elspeth Dickson/ Dr Steve Maric / Dr Daniela Fernandes |                               |

|  |                          |                             |                          |                  |
|--|--------------------------|-----------------------------|--------------------------|------------------|
| <b>Legal Name</b>                          | (Title)                  | First Name                  | Middle Name(s)           | Family Name      |
| <b>Other Name(s)</b><br>(e.g. maiden name) |                          | <b>Preferred Name(s)</b>    |                          |                  |
| <b>Birth Details</b>                       |                          | Day / Month / Year of Birth | Place of Birth           | Country of birth |
| <b>Gender</b>                              | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | Occupation       |
|  | Male                     | Female                      | Gender Diverse           |                  |

|  |   |                       |                          |
|--|---|-----------------------|--------------------------|
| <b>Usual Residential Address</b>                   | House (or RAPID) Number and Street Name       | Suburb/Rural Location | Town / City and Postcode |
| <b>Postal Address</b><br>(if different from above) | House Number and Street Name or PO Box Number | Suburb/Rural Delivery | Town / City and Postcode |

|                          |              |              |                 |
|--------------------------|--------------|--------------|-----------------|
| <b>Contact Details</b>   | Mobile Phone | Home Phone   | Email Address   |
| <b>Emergency Contact</b> | Name         | Relationship | Contact Details |

|                            |  |                                      |   |
|----------------------------|--|--------------------------------------|---|
| <b>Transfer of Records</b> | <i>In order to get the best care possible, I agree to this Practice obtaining my records from my previous Doctor. I also understand that I will be removed from my previous practice's register, as I can only be enrolled at one practice in New Zealand at a time.</i> |                                      |   |
|                            | <input type="checkbox"/> Yes, please request a transfer of my records  | <input type="checkbox"/> No transfer | <input type="checkbox"/> Not applicable |
|                            | Previous Doctor and/or Practice Name   | Address / Location                   |   |

|  |   |  |   |  |
|--|---|--|---|--|
| <b>Ethnicity Details</b><br>Which ethnic group(s) do you belong to?<br><br><i>Tick the space or spaces which apply to you.</i> | <input type="radio"/> <b>New Zealand European</b><br><input type="radio"/> <b>Māori</b><br>Iwi/Hapū: _____<br>_____<br>_____  | <b>Community Services Card</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No    Card Number _____<br>Day / Month / Year of Expiry _____  |   |  |
|  | <input type="radio"/> <b>Samoan</b><br><input type="radio"/> <b>Cook Island Māori</b><br><input type="radio"/> <b>Tongan</b><br><input type="radio"/> <b>Niuean</b><br><input type="radio"/> <b>Chinese</b><br><input type="radio"/> <b>Indian</b><br><input type="radio"/> <b>Other</b> (such as Dutch, Japanese, and Tokelauan).<br>Please state:<br>_____<br>_____ | <b>High User Health Card</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No    Card Number _____<br>Day / Month / Year of Expiry _____  |   |  |
|  |   | <b>Smoking Status</b><br><input type="checkbox"/> Current smoker/vaper <input type="checkbox"/> Recently quit <input type="checkbox"/> Ex-smoker/vaper (over 1 year) <input type="checkbox"/> Never smoked/vaped |   |  |
|  |   | Would you like help to quit?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | <input checked="" type="checkbox"/> <b>I Authorise Kowhai Surgery to contact me via Text Message</b><br><input checked="" type="checkbox"/> <b>I Authorise Kowhai Surgery to contact me via Email</b> |  |

## My Declaration of Entitlement and Eligibility

|   |                          |
|---|--------------------------|
| <p><b>I am entitled to enrol</b> because I am residing permanently in New Zealand.<br/> <i>The definition of residing permanently in NZ is that you intend to be a resident in New Zealand for at least 183 days in the next 12 months.</i></p> | <input type="checkbox"/> |
|---|--------------------------|

**I am eligible to enrol** because:

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

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 current work visa/permit and can show that I can legally 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 old and in the care and control of a parent/legal guardian/adopting parent who meets one criterion in clauses a - f above <b>OR</b> 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 New Zealand 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 New Zealand and receiving funding from a New Zealand University under the Commonwealth Scholarship and Fellowship Fund.   | <input type="checkbox"/> |

|   |                          |   |
|---|--------------------------|---|
| <p><b>I confirm that, if requested, I can provide proof of my eligibility</b></p> | <input type="checkbox"/> | <p>Evidence sighted (Office use only)</p> |
|---|--------------------------|---|

## My Agreement to the Enrolment Process

*(Parent or Caregiver to sign if you are under 16 years old)*

**I intend to use this** practice as my regular and ongoing provider of general practice / GP / health care services.

**I understand** that by enrolling with this practice I will be included in the enrolled population of this practice's The New Zealand Primary Health Organisation Limited "thePHO", and my name address and other identification details will be included on the 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 understand** the Use of Health Information Privacy 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.

|                          |           |                    |                          |                          |
|--------------------------|-----------|--------------------|--------------------------|--------------------------|
| <b>Signatory Details</b> | 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.**

|  |   |                         |               |
|--|---|-------------------------|---------------|
| <b>Authority Details</b><br><i>(where the signatory is not the enrolling person)</i> | Full Name   | Relationship to patient | Contact Phone |
|  | Legal basis of authority (e.g. parent of a child under 16 years of age) |                         |               |