PATIENT ENROLMENT FORM

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

Fields shaded in are compulsory.	**EDI Number: KOWHAISU** **GP2GP: Kowhai Surgery NZMC No: 0000** **GP Providers:** 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)	First Name	Middle Name(s)	Family Name
Other Name(s) (e.g. maiden name)			**Preferred Name(s)**	
Birth Details		Day / Month / Year of Birth	Place of Birth	Country of birth
Gender		☐ Male ☐ Female ☐ Gender Diverse	**Occupation** Work: Name /Address /Phone	

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	Name		Relationship	Contact Details

Transfer of Records	*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.*		
	☐ Yes, please request a transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Address / Location	

Ethnicity Details
Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you.

- ○ **New Zealand European**
- ○ **Māori**
  Iwi/Hapū: _____
  _____
  _____
- ○ **Samoan**
- ○ **Cook Island Māori**
- ○ **Tongan**
- ○ **Niuean**
- ○ **Chinese**
- ○ **Indian**
- ○ **Other** (such as Dutch, Japanese, and Tokelauan). Please state:

Community Services Card

☐ Yes ☐ No

Card Number Day / Month / Year of Expiry

High User Health Card

☐ Yes ☐ No

Card Number Day / Month / Year of Expiry

Smoking Status

☐ Current smoker/vaper
☐ Recently quit
☐ Ex-smoker/vaper (over 1 year)
☐ Never smoked/vaped

Would you like help to quit?

☐ Yes
☐ No

☐ **I Authorise Kowhai Surgery to contact me via Text Message**

☐ **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. *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 am eligible to enrol because:

a	**I am a New Zealand citizen** *(If yes, tick the box and proceed to **'I confirm that, if requested, I can provide proof of my eligibility'** below)*	☐

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).	☐
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.	☐
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).	☐
e	I am an Interim Visa Holder who was eligible immediately before my Interim Visa started.	☐
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.	☐
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 **OR** in the control of the Chief Executive of the Ministry of Social Development.	☐
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).	☐
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme.	☐
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.	☐

I confirm that, if requested, I can provide proof of my eligibility	☐	Evidence sighted (*Office use only*)

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.

Signatory Details	**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 *(where the signatory is not the enrolling person)*	Full Name	Relationship to patient	Contact Phone
	Legal basis of authority (e.g. parent of a child under 16 years of age)		