Glenavon Doctors Surgery

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AUCKLANDPHO

ENROLMENT FORM

PLEASE TICK

NHI

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr

Legal Name / middle Name

Family Name

Preferred Name

Other Names known by - *(e.g. maiden name)*

☐ Male ☐ Female ☐ Gender Diverse

Country of Birth:

Place of Birth:

Occupation:

Physical Address *

Street or Rapid Rural Number

Name of Street

Suburb

City/Town

Post code

Postal Address if different from above

Date of Birth

Day *Month* *Year*

Community Services Card No.

expiry date *Day* *Month* *Year*

High User Health Card No.

expiry date *Day* *Month* *Year*

Contact Details: Day phone | Night phone | Mobile phone | Email

Next of Kin / Emergency Contact: Name of person to contact | Relationship | Phone number | Address of Contact

☐ I agree to receiving txt and/or email messages?

Which ethnic group do you belong to?
Mark the space or spaces which applies to you *

- ☐ New Zealand European
- ☐ Maori
- ☐ Samoan
- ☐ Cook Islands Maori
- ☐ Tongan
- ☐ Niuean
- ☐ Chinese
- ☐ Indian
- ☐ **Other / Please State** - ie: Dutch, Asian, Japanese

DO YOU HAVE PRIVATE MEDICAL INSURANCE?
List your insurance provider

Provider

Customer no.

SMOKING STATUS *(if over 15 years of age)*

- ☐ **Never Smoked**
- ☐ **Ex Smoker** ▶ ☐ **Greater than 12 months** ▶ ☐ **Less than 12 months**
- ☐ **Current Smoker** ▶ **Would you like support to quit?** ▶ ☐ **YES** ▶ ☐ **NO**

Transfer of Records: In order to get the best possible care, I agree to the Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register

☐ YES ☐ NO ☐ NOT APPLICABLE

Doctor's Name:

Address / Location:

Please Sign:

Please turn over - for eligibility, consent and signature ▶

Enrolment in the Practice / Primary Health Organisation (PHO)

My declaration of entitlement and eligibility

I am entitled to enrol because I am residing permanently in New Zealand.

I intend to use Glenavon Doctors Surgery as my regular and ongoing provider of general practice / GP / First Level primary health care services.

I am eligible to enrol because I meet one of the following criteria: **(please tick)**

- ◯ A. I am a New Zealand citizen AND I am currently residing permanently in New Zealand OR
- ◯ B. I hold a residence permit visa AND have been in New Zealand for at least 2 years, or hold a current returning residents visa OR
- ◯ C. I am an Australian citizen or an Australian permanent resident able to show that my total stay in New Zealand is or will be for at least 2 years OR
- ◯ D. I have a current work visa / permit and can show that I am legally able to be in New Zealand for at least 2 years (previous permits included) OR
- ◯ E. I am an interim visa holder who was eligible immediately before my interim visa started
- ◯ F. I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets on criterion in clauses A-E above OR in the control of the Chief Executive of the Ministry of Social Development
- ◯ G. 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
- ◯ H. I am a Ministry of Education Foreign Language Teaching Assistant OR
- ◯ I. I am on a New Zealand Official Development Assistance or Commonwealth scholarship (or my partner/parent is a NZODA scholarship holder).

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

Note: We will retain a copy for eligibility purposes only

My agreement to the enrolment process

Note: Parent or caregiver to sign if you are under 16 years

I choose to enrol with 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 Glenavon Doctors Surgery I will be enrolled with the Primary Health Organisation (PHO) this practice belongs to, and my name, address and other identification details will be included on both the Practice, PHO and National Enrolment Service Registers.

I understand that if I visit another 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 with the PHO, and their 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 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.

Self signing Authority

	Day / Month / Year
Signature	Date

OR Signed by Authority*

Full name of Authority	Contact phone number	Relationship
Address	Signature of Authority	Day / Month / Year

Detail the basis of Authority (e.g. parent of a child under 16):

* An Authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.