



Enrolment Form

				*NHI			
Title (Circle)		Mr Mrs Ms Miss Dr		*First Name(s)		*Family Name	
Preferred Name				Other names known by			
*Gender		<input type="checkbox"/> Male		<input type="checkbox"/> Female		*Place/Country of birth	
Physical Address		Street (Rapid) Number		Street		*Date of Birth	
		Suburb		City/Town		Postcode	
		City/Town				Postcode	
Postal Address						*Community Services Card <input type="checkbox"/> Yes <input type="checkbox"/> No Card No: _____ Expiry Date: ___/___/___	
Postal Address						*High User Health Card <input type="checkbox"/> Yes <input type="checkbox"/> No Card No: _____ Expiry Date: ___/___/___	
Contact Details		Day Phone		Night Phone		Cell Phone	
Emergency Contact		Name of Contact Person		Relationship		Phone Number	
						Other Contact Details	
Which ethnic group do you belong to?				Employer Details			
Mark the space or spaces which apply to you:				Employer Name			
New Zealand European				Address Line 1			
Māori				Address Line 2			
Samoaan				Phone			
Cook Islands Maori				Transfer of Records 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A I understand that transferring my medical records indicates that I will no longer be registered with Doctor's name: _____			
Tongan							
Niuean							
Chinese							
Indian							
Other (please state):							
Please tick which is your preferred clinic (GP2GP address: tkorowai)							
Thames Office 210 Richmond Street, PO Box 605 Thames 3540 Ph 07 868 0033 Fax 07 868 5389 GP Medical Council No: Dr Robert Rigby 19362		<input type="checkbox"/>		Te Aroha Office 221 Whitaker Street Te Aroha 3320 Ph 07 884 9208 Fax 07 884 7582 GP Medical Council No: Dr B Werlberger 22507		<input type="checkbox"/>	
Paeroa Office 43 Belmont Road Paeroa 3600 Ph 07 862 9284 Fax 07 862 9283 GP Medical Council No: Dr Andre De Lange 35851		<input type="checkbox"/>		Coromandel Office 225 Kapanga Road Coromandel 3506 Ph 07 866 8084 Fax 07 866 8094 GP Medical Council No: Dr Wayne Ruby 68092		<input type="checkbox"/>	
Previous Clinic Details							
Address				Nurses name			
Phone				Fax			
Other GP Services I have been to:							
Name of Clinic		Address			Phone		Fax

See page 2 - for eligibility, consent and signature

NHI #:

I intend to use Te Korowai Hauora o Hauraki as my regular and on-going provider of general practice / GP / First Level primary health care services.

I am eligible to enrol because I live in New Zealand and meet one of the following criteria:

- a) I am a New Zealand citizen **or**
- b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) **or**
- 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 **or**
- 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) **or**
- e) I am an interim visa holder who was eligible immediately before my interim visa started **or**
- 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 **or**
- 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**
- h) I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder **or**
- i) 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) **or**
- j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme **or**
- k) I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund.

My agreement to the enrolment process
NB: 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 this practice 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 and the PHO Enrolment Register.
- 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 Health Information Privacy Statement. I agree to inform the practice of any changes in my eligibility.

I agree to receiving txt to remind for appointments	<input type="checkbox"/> Yes <input type="checkbox"/> No	I agree to receiving emails for health promotional purposes only	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Signature:

Date:

OR Signed by designated signatory who is able to sign on behalf of client

Full name of signatory:		Relationship to client:	
Address		Phone number:	

Signature:

Date:

I would like to receive the quarterly Te Korowai newsletter via email	<input type="checkbox"/> Yes <input type="checkbox"/> No	My email address to send the Te Korowai newsletter to is: (please provide email address in box on right) → → →	
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