
 <p>Rakaia Medical Centre caring for your health</p>	<p>Rakaia Medical Centre (RE) ENROLMENT FORM</p>	 <p>WAITAHA PRIMARY HEALTH</p>
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PO BOX 36, Rakaia 7743	03 303 5002 reception@rakaiamedical.co.nz	EDI: rakaiamc	NHI (Office use only)
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****Fields are compulsory (anyone over the age of 16 years MUST complete their own form).**

Name	(Title)	**Given Name	**Other Given Name(s)	**Family Name
Preferred Pronoun		Preferred Name	Other Name(s)	Maiden Name
**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"/> Another (please state)	Occupation

**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
Next of Kin			
Emergency Contact	Name	Relationship	Mobile (or other) Phone

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	Card Number

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.</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

<p>** Ethnicity Details Which ethnic group(s) do you belong to?</p> <p><i>Tick the space or spaces which apply to you.</i></p> <p>An interpreting service is available if English is not your first language.</p> <p>Please see Receptionist for more information.</p>	<p><input type="radio"/> New Zealand European</p> <p><input type="radio"/> Maori</p> <p>Iwi:</p> <p>.....</p> <p>.....</p> <p><input type="radio"/> Samoan</p> <p><input type="radio"/> Cook Island Maori</p> <p><input type="radio"/> Tongan</p> <p><input type="radio"/> Niuean</p> <p><input type="radio"/> Chinese</p> <p><input type="radio"/> Indian</p> <p><input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state</p> <p>.....</p>	<p>Smoking Status (applies to 15 years & over)</p> <p>Current Smoker <input type="checkbox"/> Would you like support to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Never Smoked <input type="checkbox"/></p> <p>Ex-smoker <input type="checkbox"/> Quit date: _____</p> <hr/> <p>Are you happy to receive text messages to remind you about appointments and upcoming recalls? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <hr/> <p>Online Services Would you like to register with our online service to book appointments, request prescriptions and view test results? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>To register, you must be over 16 and have your own unique email address. Please confirm your email address below:</p> <p>.....</p> <hr/> <p>Primary language spoken: English <input type="checkbox"/> Other <input type="checkbox"/> Please state:</p>
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**My declaration of entitlement and eligibility

I am entitled to enrol because I am residing permanently in New Zealand. <i>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</i>	<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, if requested, 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 (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 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"/>

** I confirm that I can provide proof of my eligibility	<input type="checkbox"/>	Passport	Birth Certificate
		Visa	CSC/Gold Card
Evidence sighted <i>(Office use only)</i>			

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 if I visit another health care provider where I am not enrolled I may be charged a higher fee.

I understand that by enrolling with this Practice I will be included in the enrolled population of Waitaha Primary Health (Primary Health Organisation) and my name address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers.

I understand that my practice will have access to my Shared Care Records (HealthOne) from other health providers.

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 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 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	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.

Authority Details <i>(where signatory is not the enrolling person)</i>	Full Name	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age)		