



ŌTOMED LTD *trading as* ŌTOROHANGA MEDICAL ENROLMENT FORM

Anyone 16 years & over must complete their own enrolment form

<i>Office Use Only:</i>		<i>Received by:</i>	<i>Entered by:</i>	<i>Checked by:</i>	<i>NHI:</i>
Legal Name	Title	Surname	First Name	Middle Name	
Other Name(s) (eg. maiden name)		Preferred Name			
Birth Details		Day / Month / Year	Place of Birth	Country of birth	
*Gender – you would like to be identified as		<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender Diverse (please state)	
					Sex (at birth) <input type="checkbox"/> Female <input type="checkbox"/> Male

Usual Residential Address	House (or RAPID) Number & Street	Suburb/Rural Location	Town / City / Postcode
Postal Address (if different from above)	House Number, St Name or PO Box	Suburb/Rural Delivery	Town / City / Postcode
Contact Details	Work Phone	Mobile Phone	Home Phone
	Email Address		
Contact Methods	<i>Please circle all methods of contact that are suitable to you</i>		
	Cell Phone	Home Phone	Email Post Txt
Consent to use text messaging (Please Circle) Yes / No			

* Ethnicity Details	Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>		
	<input type="checkbox"/> 21 Maori Iwi _____		
	<input type="checkbox"/> 31 Fijian		
	<input type="checkbox"/> 33 Tongan		
	<input type="checkbox"/> 32 Cook Island Maori		
	<input type="checkbox"/> Samoan		
	<input type="checkbox"/> 43 Indian		
	<input type="checkbox"/> 42 Chinese		
	<input type="checkbox"/> 11 New Zealand European		
	<input type="checkbox"/> Other (Tokelauan, Dutch, Japanese)	Please Specify	<input style="width: 150px; height: 20px;" type="text"/>

Account Holder	<input type="checkbox"/> Self <input type="checkbox"/> Company <input type="checkbox"/> Other (Please Specify)	Account Holder Name
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An Account Holder is responsible for ensuring that all accounts under their name are paid for on the day of charge. Permission must be received from appointed Account Holders, unless they have been appointed by a dependent (child under 18 years old).

Preferred Pharmacy:

Community Services Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Expiry Day / Month / Year	Card Number
High User Health Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Expiry Day / Month / Year	Card Number

<u>PATIENT'S</u> Occupation	
Employer and Company Phone Number	
Company Address	

NOK Emergency Contact	Name & Surname	Relationship	Contact Number

Consent to Enrolment in Breast Screening Programme (women aged 45-70 years only):
Yes / No Please circle one

Smoking is an important factor influencing health. If you are aged 15 & over please circle the box that applies to you. Vapers please complete smoking section also:

Current Vaper (with nicotine)
 Current Smoker (tobacco)
 Ex-Smoker
 Never Smoked

If you currently smoke tobacco, would you like some free help to quit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you allergic to any medication? If so, what?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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 (If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below)	<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, if requested, I can provide proof of my eligibility		<input type="checkbox"/> Evidence sighted (Office use only)

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 by enrolling with this practice I will be included in the enrolled population of this practice's Primary Health Organisation (PHO) Midlands Regional Health Network Charitable Trust, 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 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 have read and I agree to the Ōtorohanga Medical Terms and Conditions.

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	<input type="checkbox"/> Self Signing	<input type="checkbox"/> Authority
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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)		