ŌTOROHANGA MEDICAL
Te Whare Hauora o Ōtorohanga

Anyone over age of 16 years must complete their own enrolment form

NHI *(Office use only)*

Title:	
First Name:	
Middle Name:	
Family Name:	
Preferred Name:	
Other/Maiden Name:	
DOB:	
Place of Birth:	
Country of Birth:	

Sex (at birth) ☐ **Male** ☐ **Female**

Gender you would like to be identified as: ☐ **Male** ☐ **Female** ☐ **Gender Diverse**

Residential Address:

House number & Street

Town / City & Postcode

Postal Address: *(If different from above)*

Town / City & Location

Ethnicity:

	Maori	Iwi:
	Fijian	
	Tongan	
	Cook Island Maori	
	Samoan	
	Indian	
	Chinese	
	NZ European	
	Other (Tokelauan, Japanese, Dutch)	Please State:

Mobile:		**Home Phone:**	
Email:			
Next of Kin:	Name & Surname	Relationship	Contact Number:
Contact Methods:	*Please circle all methods of contact that are suitable to you* **Cell phone** **Home phone** **Email** **Post** **Text**		
Occupation, Employer and Company Phone Number:			
Company Address:			

CSC (Community Services Card)	☐ yes ☐ no	Expiry date	Card Number
HUHC (High User Health Card)	☐ yes ☐ no	Expiry date	Card Number
Account Holder	☐ Self ☐ Company ☐ Other (Please specify)		Account holder name and surname

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	

Smoking is an important factor influencing health

If you are aged 15 and over, please circle the space that applies to you.

Currently smoke Ex-smoker Never smoked

If you currently smoke, would you like some help to quit?	**Yes**		**No**	

Consent to enrolment in Breast Screening Programme (women aged 45-70 years only)

Yes No Please circle one

VERSION: SEPTEMBER 2021

Pinnacle Midlands Health Network

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 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 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 work visa/permit and can show that I am able to 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 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 NZ 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 NZ 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

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 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 signatory is not the enrolling person)*	Full Name	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age)		

ŌTOROHANGA MEDICAL
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Tel : 07 873 7079 ● Fax : 07 873 7078 ● 13 Kakamutu Road ● PO Box 7, Otorohanga, 3900
● reception@otorohangamc.co.nz

REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED

In order to receive the best care possible, I agree to Otorohanga Medical Centre obtaining my medical records from my previous doctor. I also understand that I will be removed from my previous medical centre's register.

Each person should complete a form. 16 years and older to sign own form.

Patient details:

Family Name: _____

Given Names: _____

Date of birth/NHI: _____

Signed: _____
(16 years and older to sign own form)

Authority Details: _____

Date: _____

Previous Medical Centre:

Name: _____

Address: _____

_____

Fax no: _____

Our practice can receive and would prefer GP2GP notes transfer

Thank you

For GP2GP transfers, please use the following info:

EDI: otoromco

☐ Dr Joyce Wong (33003)
☐ Dr Bhanu Sivakumar (62654)
☐ Dr Jo Ann Francisco (64080)
☐ Dr Russ Fernandez (65494)

Please return via fax or email to: 07 873 7078 or reception@otorohangamc.co.nz