

ENROLMENT FORM

He whare hauora Kaupapa Māori tēnei, engāri kei te tūwhera ki te katoa e noho ana ki takapū o Tapuika. He nui nei te korowai aroha, te korowai manaaki, te korowai whakaute o tō mātou whare hauora. Ko tō mātou e hiahia ai, kia noho ngātahi i runga i te whakaaro kotahi, tangata whenua mai, tangata tiriti mai.

Maurioa!!

Poutiri Wellness Centre 35 Commerce Lane, Te Puke PO Box 148, Te Puke 3153 Tel: (07) 573 0091 Email: wellness@poutiri.org	Provider: Poutiri Wellness Centre NZMC: 0000 EDI: pouwell NHI (Office use):
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* Indicates Fields that are **COMPULSORY**

Fields above for Office Use ONLY

Legal Name	Title	Surname/Family Name*	First/Given Name*
	Middle Name(s)	Preferred Name	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"/> Gender diverse (please state)*		Primary Language

Usual Residential Address	House (or RAPID) Number and Street Name*	Suburb/Rural Location*	Town / City and Postcode*
Postal Address <small>(if different from above)</small>	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
	Address		

Community Services Card	<input type="checkbox"/> Yes <input type="checkbox"/> No	High User Health Card	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Ethnicity Details* Which ethnic group(s) do you belong to? Tick the space or spaces which apply to you	<input type="radio"/> New Zealand European <input type="radio"/> Maori <input type="radio"/> Samoan <input type="radio"/> Cook Island Maori <input type="radio"/> Tongan <input type="radio"/> Niuean <input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state: <input style="width: 100%;" type="text"/>	Iwi _____ Hapu _____	Occupation _____ Employer & Address _____ Smoking Status (applies to 15 years & over ONLY) Never smoked <input type="checkbox"/> Current smoker <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Approximate Quit Date _____ Smoking is bad for your health. Would you like support to quit? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Tick the box if you DO NOT want to receive communications by: <input type="checkbox"/> Text Message <input type="checkbox"/> Patient Portal (encrypted) <input type="checkbox"/> Email (non-secure) How did you find out about us: _____		

Transfer of Records Authority	<i>In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I understand I will be removed from their practice register, as I am only able to be enrolled at one practice at a time in NZ.</i>		
	<input type="checkbox"/> Yes - please request transfer of my records <input type="checkbox"/> Not Applicable <input type="checkbox"/> No	Previous Doctor and/or Practice Name	
	Signature _____ Day / Month / Year _____	Practice Address / Location	

My preferred pharmacy is	
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Fields below for office use ONLY:

IDENTIFICATION TYPE: Passport <input type="checkbox"/>	Birth Certificate <input type="checkbox"/>	Drivers License <input type="checkbox"/>	Other: _____
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Reference number:	Date of Expiry:	Sighted by:	Date:
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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)	<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 have provided proof of my eligibility

Evidence (Visa) 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 **Poutiri Wellness Centre** I will be included in the enrolled population of **Eastern Bay of Plenty PHO** 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 or informed 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 shared 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.

I agree to the Terms and Conditions of Trade of Poutiri Wellness Centre and undertake to pay any fees applicable for Practice Services & all costs incurred in collection of any debt for myself & my dependents.

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 (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)		