



Fields with * are compulsory		Patient Enrolment Form			NHI (Office use only)	
Anyone over the age of 16 years must complete their own enrolment form						
Legal Name	Title	* Given Name	* Other Given Name	* Family Name		
Other Name(s) (eg. maiden name)			Preferred Name(s)			
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"/> Male <input type="checkbox"/> Female	
Occupation & Employer details						
Usual Residential Address	* House (or RAPID) Number & St		* 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		
Emergency Contact/NOK	Name	Relationship		Mobile (or other) Phone		
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		
* Ethnicity Details Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	<input type="checkbox"/> 11 New Zealand European <input type="checkbox"/> 21 Maori Iwi _____ <input type="checkbox"/> 31 Samoan <input type="checkbox"/> 32 Cook Island Maori <input type="checkbox"/> 33 Tongan <input type="checkbox"/> 34 Niuean <input type="checkbox"/> 42 Chinese <input type="checkbox"/> 43 Indian <input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan) Please state <input type="text"/> <input type="text"/>			Smoking is an important factor influencing health If you are aged 15 and over please tick the space that applies for you <input type="checkbox"/> Currently smoke <input type="checkbox"/> Recently quit <input type="checkbox"/> Ex-smoker (over 1 year) <input type="checkbox"/> Never smoked Smoking is hugely negative on your good health. In most cases, you will experience the benefits of quitting immediately. If you currently smoke, would you like some help to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Consents	
Consent to import clinical records from enrolled practice	<input type="checkbox"/> Consented <input type="checkbox"/> Declined
Consent to share my records on Indici SEHR	<input type="checkbox"/> Consented <input type="checkbox"/> Declined
Consent to share Health info with other Health Providers in my care	<input type="checkbox"/> Consented <input type="checkbox"/> Declined
Consent to use the provided email address to receive communication from practice (including clinical information)	<input type="checkbox"/> Consented <input type="checkbox"/> Declined

* 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)
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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 Health Information Privacy Statement as shown on the following page.

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)		

Health Information Privacy Statement

As acknowledged on the preceding page, I have read and understand the following:

Access to my Health Information

I have the right to access (and have corrected) my health information under Rules 6 and 7 of the Health Information Privacy Code 1994.

Visiting another GP

If I visit another GP who is not my regular doctor, I will be asked for permission to share information from the visit with my regular doctor or practice

If I have a High User Health Card or Community Services Card and I visit another GP who is not my regular doctor, he/she can make a claim for a subsidy, and the practice I am enrolled in will be informed of the date of that visit. The name of the practice I visited and the reason(s) for the visit will not be disclosed unless I give my consent.

Patient Enrolment Information

The information I have provided on this Enrolment Form will be:

- held by the practice
- used by the Ministry of Health to give me a National Health Index (NHI) number, or update any changes
- sent to the PHO and Ministry of Health to obtain subsidised funding on my behalf
- 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

Health Information

Members of my health team may:

- add to my health record during any services provided to me and use that information to provide appropriate care
- share relevant health information to other health professionals who are directly involved in my care

Audit

In the case of financial audits, my health information may be reviewed by an auditor for checking a financial claim made by the practice, but only according to the terms and conditions of section 22G of the Health Act (or any subsequent applicable Act). I may be contacted by the auditor to check that services have been received. If the audit involves checking on health matters, an appropriately qualified health care practitioner will view the health records.

Health Programmes

Health data relevant to a programme in which I am enrolled (e.g. Breast Screening, Immunisation, Diabetes) may be sent to the PHO or the external health agency managing this programme.

Other Uses of Health Information

Health information *which will not include my name but may include my National Health Index Identifier (NHI)* may be used by health agencies such as the District Health Board, Ministry of Health or PHO for the following purposes, as long as it is not used or published in a way that can identify me:

- health service planning and reporting
- monitoring service quality, and
- payment.

Research

My health information may be used for health research, but only if this has been approved by an Ethics Committee and will not be used or published in a way that can identify me.

Except as listed above, I understand that details about my health status or the services I have received will remain confidential within the medical practice unless I give specific consent for this information to be communicated.



Taupō Health Centre
 113 Te Heuheu Street
 Taupō 3330
 Ph (07) 378 7060
 Fax (07) 378 2255

REQUEST TO HAVE MEDICAL RECORDS TRANSFERRED TO TAUPŌ HEALTH CENTRE

(Each person Aged 16 and over must sign their own form)

In order to receive the best possible healthcare, I agree to Taupō Health Centre obtaining my medical records from my previous Doctor. I also understand that I will be removed from my previous Doctor's practice register.

<p>To:</p> <p style="text-align: center;">(Name, Address and Fax Number of previous GP)</p>

NHI	Family Name	Given Name(s)	Date of Birth

Signed:

Name:	Signature:	Date:
Current Address:		Phone:

For Previous GP:

Please transfer the medical records for the abovementioned people to Taupō Health Centre. Our preferred method of receiving records is via GP2GP, using:
EDI: taupohc; NZMC: 97070; Dr Name: Taupō Health Centre.