

Durham Health Enrolment Form

15 Durham Street, Rangiora. Ph 03 313 4659 Fax 03 313 4658. EDI: RANGIOMS

Family name		First names		Title	Gender	Date of birth
					Male Female	
Ethnicity (tick up to 3)			33	Tongan	43	Indian
10	European not defined		34	Niuean	44	Other Asian
11	NZ European/Pakeha		35	Tokelauan	51	Middle Eastern
12	Other European		36	Fijian	52	Latin American/Hispanic
21	NZ Maori		37	Other Pacific Island	53	African
30	Pacific Island not defined		40	Asian not defined	54	Other
31	Samoan		41	South East Asian	98	Declined to state
32	Cook Island Maori		42	Chinese	99	Not stated
Residential address						
Street Address						
Suburb/Rural District			Town/City		Post code	
Postal Address (if different)						
Home phone number		Mobile phone number		Work/day phone number		Occupation
Email address						
Community Service Card Number and expiry date				High User Health Card Number and expiry date		
Next of kin (full name)				Relationship		Daytime phone number
Residency Status: Do you live in New Zealand on a permanent or long term basis i.e. for more than 2 years (please tick)					Yes	No

By enrolling with this medical practice and signing this form I understand that:

I intend to use this medical practice as my main provider of primary health care.

This medical practice is contracted to a Primary Health Organisation (PHO).

The details on this form will be recorded in the medical practice enrolment register. This register will be submitted to the PHO (or its agent), District Health Board (DHB) and Ministry of Health (MoH) so that the practice can receive appropriate funding. The information I have provided on this form will be used by the MoH to update my National Health Index (NHI) information. Details of my health status or treatment will not be submitted.

This medical practice will receive government funding to subsidise my health care, reducing the amount I would otherwise have to pay for some services.

I can only be enrolled with one medical practice at any one time.

I may visit any other medical practice but this will be as a casual patient and may affect the amount I have to pay. The PHO will be informed of this visit, but not my health status or treatment, for funding purposes only.

Details about my health status or treatment will remain confidential within the medical practice unless I give specific and separate consent for this to be communicated elsewhere.

My health information, which will not identify me, may be sent to the PHO, DHB and MoH to plan, monitor and fund future primary health care services. The PHO may also be sent my health information if I am part of one of its programmes and it has obtained my specific consent for this purpose.

I retain the right to obtain access to and request correction of any of my information held by the medical practice pursuant to Section 22G of the Health Act.

I may end my enrolment with this medical practice at any time.

Is your child immunised? Can you supply records Yes No

If transferring from another medical practice

I agree that this medical practice can obtain clinical records and copies of any health information about me from the practice I previously attended for the purpose of recording my health status and to assist in my future care and treatment.

Name of previous medical practice _____

Signed _____ Name (print) _____