durham health
tiaki i te iwi o tāmaki | caring for the community

Ph: 03 313 4659 **E**: reception@durhamhealth.co.nz

Checked By:

On:

General Practice Enrolment / Re-Enrolment Form

Date: DD / MM / YY

NHI No:

Legal Name	**Title**	**Surname (Family Name)**	**Given Name (First Name)**	**Preferred Name**
Middle Name			**Other Names (if any)**	
Assigned Sex (Gender at Birth) ☐ Male ☐ Female ☐ Indeterminate		**Current Gender (if different / applicable)**		**Preferred Pronouns**
Date of Birth		**Country of Birth**		**Place of Birth (City, Town, Suburb, etc...)**
Day Phone		**Mobile Phone Number**	**Email Address**	
Residential Address: Street Address		**Suburb**		**Address: City & Postcode**
I would like my GP to send me the information about my results, recalls and other relevant Health related matters electronically via: **Text Messages** – on my mobile number and / or via **Emails** – on my email address				**Yes / No**
I give consent for my doctor to access my medical records from other health providers (HealthOne)				**Yes / No**

Occupation:	**Employer**:
Do you have **private Insurance?** ☐ Yes ☐ No	If **'Yes'**, then name of the Insurance Company?

Emergency Contact	Name	Relationship	Mobile (or other) Phone
Com. Serv. Card ☐ Yes ☐ No	Expiry Date	Card Number	

Smoking Status: **Current Smoker?** ☐ Yes ☐ No **Current Vaper?** ☐ Yes ☐ No

If yes, would you like any support to quit? ☐ Yes ☐ No
If no, please tick one of these options:
☐ **Never smoked** ☐ **Ex-smoker/vaper (more than 12months)** ☐ **Ex-smoker/vaper (less than 12 months)**

Transfer of Records	Previous Doctor and/or Practice Name (please complete even if you wish not to have your records transferred)	Address / Location
	I have enrolled with *Durham Health (part of Tamaki Health group)* practice for my ongoing care. In order to get the best care possible, **I agree to the Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register**	
	☐ Yes, please request transfer of my records	☐ No transfer ☐ Not Applicable

Kindly Send the records electronically via GP2GP to: GP Name: Durham Health NZMC No.
Our Health link mailbox address (edi): rangioms

ETHNICITY: Which ethnic group do you belong to? * Mark the space or spaces which apply to you

ETHNICITY	Tick
New Zealand European	
Māori	
Samoan	
Cook Islands Maori	
Tongan	
Niuean	
Chinese	
Indian	
Other such as DUTCH, JAPANESE, TOKELAUAN. Please state: _____	

Patient Survey From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.

Patient Survey Contact Details: As provided above ☐ **Or**

Alternative Mobile Phone Number

Alternative Email Address

☐ **I do not wish to participate in the patient survey**

Patient Initials: _____

My declaration of entitlement and eligibility for Enrolment:

I intend to use Durham Health *as my regular and ongoing provider of general practice / GP / First Level primary health care services.* **(All patients must tick)**

I am entitled to enroll because I am residing permanently in New Zealand The definition of residing permanently in NZ is that you have intend to be resident in New Zealand for at least 183 days in next 12 months	☐

For NZ Citizens - I am eligible to enroll because:

a	I am a New Zealand citizen (including those from the Cook Islands, Niue or Tokelau) *(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 entitlement 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	☐
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 understand** that by enrolling with this practice I will be enrolled with the Primary Health Organisation (PHO) this practice belongs to, and my name address and other identification details will be included on both the Practice and the PHO Enrolment Register.
- ✓ **I understand** that if I visit another 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 with the PHO, and their contact details. I have read and understood the requirements of enrolling with one PHO and choose Durham Health's PHO to be my PHO.
- ✓ **I have read and I agree** with the Health Information Privacy Statement.
- ✓ **I agree** to inform the practice of any changes in my eligibility.
- ✓ **I authorize** Durham Health (*part of Tamaki Health Group)* to pass on parts of my health information to the **Ministry Of Health.**
- ✓ **I understand** that relevant health information may be forwarded to other health professionals involved in my care.
- ✓ **I understand** that my health information is accessible by all members of the primary care team and may be accessed by other *Tamaki Health Group* practices so that continuity of care is facilitated through a shared health record.
- ✓ **I understand** that all members of the primary health care team have signed employment contracts containing confidentiality clauses or have signed confidentiality agreements and have completed privacy training so that my personal health information is kept confidential.
- ✓ **I understand** that certain information in my daily clinical records can be made confidential to one clinician only if required.
- ✓ **I also understand** that it is my right under the Health Information Privacy Code to ask to see my personal or Health Information held by the practice. I can ask for it to be corrected if it is wrong.
- ✓ **I understand** that if I choose to see another doctor I will register at that practice as a Casual Patient, and if I see a GP outside of *Tamaki Health Group* practices frequently, I may be dis-enrolled from the *Tamaki Health Group* practices.

Signatory Details	Signature	Date	For Self ☐	As Authorised Signatory ☐

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)		

(Casual Patients do NOT need to sign the form)

NHI No: _____