| WellSouth Primary Health Network Hauora Matua Ki Te Tonga | **ENROLMENT FORM** | **Junction Health**<br>1A Traders Lane, Cromwell, 9310<br>Phone: 034454688 Fax: 034454622 | Junction Health Central Wellness |
|---|---|---|---|

| *** Compulsory Fields** | **GP2GP:** | **Dr Keith Abbott - NZMC 40232**<br>**Dr Elina Kiuru - NZMC 63254**<br>**Dr Paul Johns – NZMC 13733** | |
|---|---|---|---|
| | **EDI:** | **juncthth** | NHI *(Office use only)* |

| ***Name** | (Title) | Given Name | Middle Name | Family Name |
|---|---|---|---|---|
| **Other Name(s)**<br>(eg. maiden name)<br>Please tick the name you prefer to be known as | | | | |
| ***Birth Details** | | Day / Month / Year of Birth | Place of Birth | Country of birth |
| ***Gender** | ☐ Male | ☐ Female | ☐ Gender diverse (please state) | Occupation |

| ***Usual Residential Address** | House (or RAPID) Number and Street Name | Suburb/Rural Location | Town / City and Postcode |
|---|---|---|---|
| **Postal Address**<br>*(if different from above) | House Number and Street Name or PO Box Number | Suburb/Rural Delivery | Town / City and Postcode |
| **Contact Details** | Mobile Phone / Home Phone | Email Address | |
| **Emergency Contact** | Name | Relationship | Mobile (or other) Phone |

| **Employer Details** | Company | Phone | Address |
|---|---|---|---|

| **Transfer of Records** | *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 |
| | Previous Doctor and/or Practice Name | Address / Location | |

***Ethnicity Details**
Which ethnic group(s) do you belong to?
***Tick the space or spaces which apply to you***

- ○ New Zealand European
- ○ Maori
- ○ Samoan
- ○ Cook Island Maori
- ○ Tongan
- ○ Niuean
- ○ Chinese
- ○ Indian
- ○ Other (such as Dutch, Japanese, Tokelauan). Please state

| **Community Services Card** | ☐ Yes | ☐ No |
|---|---|---|
| Day / Month / Year of Expiry | Card Number | |
| **High User Health Card** | ☐ Yes | ☐ No |
| Day / Month / Year of Expiry | Card Number | |

**Smoking Status:**
Never Smoked ☐ Current Smoker ☐ Ex Smoker ☐ Quit date.....
Would you like help to Quit? ☐ Yes ☐ No

**Office Use Only:**
**Date Received:.....Signed:**.....
**Notes Requested:.....Signed:**.....

## *My declaration of entitlement and eligibility

| | |
|---|---|
| ***I am entitled to enrol** because I am residing permanently in New Zealand.<br>*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 Junction Health I will be included in the enrolled population of WellSouth Primary Health Network, 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 understand** that the practice may share my health information between healthcare providers using HealthOne, a secure system for storing electronic patient records and that all information is kept confidential and checks are in place to monitor all access.

**I understand** that further information on HealthOne is available from the practice on request.

**I agree** to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

**Payment & Debt Recovery** – Payment is expected in full on the day of consultation. If you are unable to pay on the day, please discuss with reception and a fee may be added to your account.

**I agree to be liable for any debt recovery costs I may incur for non-payment of my account.**

| | | | | |
|---|---|---|---|---|
| **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 |
| **Authority Details** | Basis of authority (e.g. parent of a child under 16 years of age) | | |