SOUTH SEAS HEALTHCARE ENROLMENT FORM

Shop 11, PO Box 61033, Otara Mall, Otara, Auckland 2159 EDI: sshldiab
Phone: (09) 273-9017 Fax: (09) 273-9026

				NHI*	
Title		**First Name(s)***		**Family Name***	
Preferred Name				**Other Names Known By**	**(e.g. maiden name)**
Gender*	☐ **Male** ☐ **Female**			**Country of birth***	
Physical Address*	Street number	Name of Street		**Date of Birth***	_____/_____/_____ Day Month Year
	Suburb			**High User Health Card**	**YES / NO**
	City/Town	Postcode		**Card Number:** **Expiry Date:**	
Postal Address				**Community Services Card**	**YES / NO**
				Card Number: **Expiry Date:**	
Contact Details	**Day Phone**	**Night Phone**	**Cell Phone**	**Email**	
Emergency contact	**Name of person to contact**	**Relationship**	**Phone number**	**Other contact details**	

Which ethnic group do you belong to? **Tick the space or spaces which apply to you ***	**Smoking Status**	**Eligibility** *(see over page)** **I confirm that, if requested, I can provide proof of my eligibility. I agree to inform the practice of any changes in my eligibility.**
☐ 11 New Zealand European	☐ Current	☐ Not Eligible
☐ 21 Māori Iwi:	☐ Ex-Smoker	***Eligible under criteria** (enter applicable letter from list over page) *
☐ 31 Samoan		
☐ 32 Cook Islands Maori	☐ Never Smoked	**I have read and agree** with the Health Information Privacy Statement. (tick) *
☐ 33 Tongan		
☐ 34 Niuean	**Transfer of Records** ☐Yes ☐No	
☐ 35 Tokelauan	In order to get the best care possible, I agree to the transfer of my records from my previous Doctor. I understand, I will be removed from their practice register. **Doctor's Name:**	
☐ 42 Chinese		
☐ 43 Indian		
☐ 54 Other such as DUTCH, JAPANESE Please state:	**Address / Location**: Phone/Fax:	

Dependants listed on this form will also be enrolled in the PHO as long as I am legally entitled to sign on their behalf

NHI	First Names	Family Name	Gender	Ethnicity/Ethnicities	Date of Birth

SIGNATURE*	**DATE***
	/ / Day Month Year

OR Signed by AUTHORITY An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Full Name of Authority	Contact Phone Number	Relationship
Address	Signature of Authority	/ / Day Month Year
Detail the basis of authority (e.g. parent of a child under 16):		

please read this sheet and identify on your enrolment form which criteria provides your eligibility to funded health services

Enrolment in the Practice / Primary Health Organisation (PHO)

I intend to use this practice as my regular and ongoing provider of general practice / GP / First Level primary health care services.

I am eligible to enrol because **I live in New Zealand** and meet one of the following criteria:

a) I am a New Zealand citizen **OR**

b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) **OR**

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 **OR**

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) **OR**

e) I am an interim visa holder who was eligible immediately before my interim visa started **OR**

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 **OR**

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**

h) I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder **OR**

i) 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) **OR**

j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme **OR**

k) 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.

My Agreement To The Enrolment Process

NB: Parent or caregiver to sign if you are under 16 years

I choose to enrol with this practice as my regular and on going provider of general practice / GP / First Level primary health care services.

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.

Health Information Privacy

I agree to the practice sharing my health information with other health providers involved in my healthcare.

I also agree to my information may be used for practice quality/audit activities and to being included in the practice screening, recall and health programmes, and used as part of practice and population health planning.