

EDI: northend	GP2GP: Andrew Wilson 18544 PO Box 166 Oamaru 9444 Ph 03 4370347 Fax : 03 437 0036	NHI
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Legal Name	(Title)	Given Name	Other Given Name(s)	Family Name
Other Name(s) (eg. maiden name) Please tick the name you prefer to be known as				
Birth Details				
Day / Month / Year of Birth		Place of Birth		Country of birth
Gender				
<input type="checkbox"/> Male		<input type="checkbox"/> Female		<input type="checkbox"/> Gender diverse (please state)
				Occupation

Usual Residential Address	House (or RAPID) Number and Street Name	Suburb/Rural Delivery	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

Contact Details	Mobile Txt Message Yes/No	Home Phone	Email Address
Emergency Contact	Name	Relationship	Mobile (or other) Phone

ONLINE BOOKINGS (Over 16 yrs only) If you want to make online bookings you will need to sign up with **Manage My Health Portal** If you wish to Register please enter your email you wish for online bookings _____ where a link will be sent to that email for you to activate your Manage My Health account to make online bookings.

Community Services Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number
High User Health Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number

Transfer of Records	<i>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.</i>		
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor and/or Practice Name		Address / Location

Ethnicity Details Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	<input type="radio"/> New Zealand European	Patient Survey <i>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.</i>
	<input type="radio"/> Maori	
	<input type="radio"/> Samoan	
	<input type="radio"/> Cook Island Maori	
	<input type="radio"/> Tongan	
<input type="radio"/> Niuen	Patient Survey Contact Details As provided above (or) Alternative Mobile Phone	
<input type="radio"/> Chinese		
<input type="radio"/> Indian	Alternative Email Address	
<input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state	<input type="checkbox"/> I do not wish to participate in the Patient Survey	
	Please circle your smoking status Never Smoked Smoker Trying to give up Ex-Smoker Would like support to Quit Yes/No	

My declaration of entitlement and eligibility

I am entitled to enrol because I am residing permanently in New Zealand.

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 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)	<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	<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

Evidence to be provided (e.g. Passport)

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 AWGP LTD trading as North End Health Centre and Junction Doctors I will be included in the enrolled population of **WELLSOUTH**, 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 agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

I understand that the clinicians in this practice may use voice recorder software to write their clinical notes which is an audio to txt transcription to keep note of your visit.

I agree to the paying of my consultation on the day. Payment by account will be at the discretion of the Practice Manager.

Signatory Details	Signature	Day / Month / Year	<input type="checkbox"/>	<input type="checkbox"/>
			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 <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)		