Papakura Marae Health Centre
Enrolment Form

PERSONAL INFORMATION					
SURNAME:		TITLE		NHI	
FIRST NAME:				DATE OF BIRTH	
MIDDLE NAME:				GENDER	MALE / FEMALE
PREF NAME:					
STREET:					
SUBURB					
CITY		POST CODE			
EMAIL ADDRESS:					
WORK PHONE:		HOME PHONE:			
MOBILE:		RECEIVE TEXTS?	**YES / NO**		

Nationality/Ethnicity - Please circle all that apply -						
21 MAORI	35 TOKELAUAN	36 FIJIAN	34 NIUEAN	33 TONGAN	32 COOK ISLAND MAORI	31 SAMOAN
37 OTHER PACIFIC ISLAND	30 PACIFIC NOT FURTHER DEFINED	41 SOUTH EAST ASIAN	43 INDIAN	42 CHINESE	44 OTHER ASIAN	40 ASIAN NOT FURTHER DEFINED
52 LATIN AMER/ HISPANIC	53 AFRICAN	51 MIDDLE EASTERN	54 OTHER	12 EUROPEAN	10 OTHER EUROPEAN	11 NZ EUROPEAN

CARDS					
COMMUNITY SERVICES C ARD	NO.	START DATE:		EXPIRY DATE:	
HIGH USER CARD	NO.	START DATE:		EXPIRY DATE:	

EMERGENCY CONTACT			
Full name:			
Home phone:		Mobile phone:	
RELATIONSHIP TO YOU:			

EMPLOYMENT (For ACC Claims)			
Employer		Employer Address	
Position/Role			

PAPAKURA MARAE SERVICES (for full details go to www.papakuramarae.co.nz)

Papakura Marae offer several services, please indicate below if you would like someone to contact you

EARLY YEARS SERVICE HUB	TEEN PARENTING	TAMARIKI ORA
WHANAU ORA	FAMILY START	SOCIAL SERVICES

TRANSFER OF RECORDS

In order to get the best care possible, I agree to the Papakura Marae Health Centre obtaining my medical records from my previous Doctor. I also understand that I will be removed from their practice register

GP NAME:	DR.
PRACTICE NAME:	
PRACTICE ADDRESS:	

ENROLMENT IN THE PRACTICE / PRIMARY HEALTH ORGANISATION (PHO)	
I intend **to use** Papakura Marae Health Centre as my regular and ongoing provider of primary health care services and **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	Yes / No
B. I hold a resident visa or a permanent resident visa (or a resident permit if issued before December 2010)	Yes / No
C. I am an Australian Citizen or Australian permanent resident AND able to show I have been in New Zealand or intend to reside in New Zealand for at least 2 consecutive years. (The definition residing in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months)	Yes / No
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)	Yes / No
E. I am an interim visa holder who was eligible immediately before my interim visa started	Yes / No
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	Yes / No
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	Yes / No
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	Yes / No
I. I am a NZ Aid Programme student studying in NZ and receiving Official Development Assistance (or their partner or child under 18 years old)	Yes / No
J. I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	Yes / No
K. I am a Commonwealth Scholar holder studying in NZ and receiving funding from a New Zealand University under the Commonwealth Scholarship and Fellowship Fund	Yes / No
AND I confirm that I can provide proof of my eligibility (birth certificate/passport/super goldcard)	

PATIENT DECLARATION

Please note: Parent or caregiver must <u>sign</u> if you are <u>under 16 years</u>

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 Papakura Marae Health Centre I will be included in the enrolled population National Hauora Coalition, 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 agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled

	/ /
	Day Month
SIGNATURE	**DATE**

OR Signed by AUTHORITY for patients under 16 (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 to patient**

National Hauora Coalition