

<b>Fields with * are compulsory</b>	<b>Anyone over age of 16 years must complete their own enrolment form</b>	<b>NHI (Office use only)</b>
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<b>Legal Name</b>	Title	* Given Name	* Other Given Name	* Family Name
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Other Name(s) <small>(eg. maiden name)</small>		<b>Preferred Name(s)</b>	
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<b>Birth Details</b>	* Day / Month / Year	* Place of Birth	* Country of birth
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<b>Sex</b> (at birth)	* <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Gender</b> you would like to be identified as	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse (please state)

<b>Usual Residential Address</b>	* House (or RAPID) Number & St	* Suburb/Rural Location	* Town / City & Postcode
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<b>Postal Address</b> <small>(if different from above)</small>	House Number & St Name or PO Box	Suburb/Rural Delivery	Town / City & Postcode
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<b>*Occupation &amp; Employer Details</b>	Company Name	Occupation
	Company Address	Work Phone

<b>*Contact Details</b>	Mobile Phone	Home Phone	* Email Address
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*Do you consent to the practice sending TEXT messages for the purpose of recalls, surveys & updating your details?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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*Do you consent to the practice sending EMAILS for the purpose of recalls, surveys & updating your details?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<b>* Emergency Contact/NOK</b>	Name	Relationship	Mobile (or other) Phone
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<b>Community Services Card</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Expiry Day / Month / Year	Card Number
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<b>High User Health Card</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Expiry Day / Month / Year	Card Number
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<b>* Ethnicity Details</b>	<input type="checkbox"/> 11 New Zealand European <input type="checkbox"/> 21 Maori Iwi _____ <input type="checkbox"/> 31 Samoan <input type="checkbox"/> 32 Cook Island Maori <input type="checkbox"/> 33 Tongan <input type="checkbox"/> 34 Niuean <input type="checkbox"/> 42 Chinese <input type="checkbox"/> 43 Indian <input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan) Please state <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<b>*Smoking is an important factor influencing health</b> If you are aged 15 and over please tick the space that applies for you  <input type="checkbox"/> Currently smoke <input type="checkbox"/> Recently quit <input type="checkbox"/> Ex-smoker (over 1 year) <input type="checkbox"/> Never smoked  Smoking is hugely negative on your good health. In most cases, you will experience the benefits of quitting immediately.  <b>If you currently smoke, would you like some help to quit?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>*Alcohol Consumption (Circle one)</b>  Non / Social / Heavy  <hr/> <b>*Would you like to sign up to Manage My Health?</b>   (Circle one)  <b>Yes / No</b>
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## \* My declaration of entitlement and eligibility

<p><b>I am entitled to enrol</b> because I am residing permanently in New Zealand.  <i>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></p>	<input type="checkbox"/>
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**I am eligible to enrol** because:

a	<p><b>I am a New Zealand citizen</b> (If yes, tick box and proceed to <b>I confirm that, if requested, I can provide proof of my eligibility</b> below)</p>	<input type="checkbox"/>
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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)	<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 <b>OR</b> in the control of the Chief Executive of the Ministry of Social Development	<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"/>

<p><b>I confirm</b> that, if requested, I can provide proof of my eligibility</p>	<input type="checkbox"/>	Evidence sighted ( <i>Office use only</i> )
My work/student/visitor/ other visa is valid for the period of	Year(s):	Expiry Date:

## 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 Redicare Family Practice, I will be included in the enrolled population of the Midlands Regional Health Network Charitable Trust, 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.

<b>Signatory Details</b>	* Signature	* Day / Month / Year	<input type="checkbox"/> Self-Signing	<input type="checkbox"/> Authority
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**An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.**

<b>Authority Details</b> <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)			

Aug. 2020