PATIENT ENROLMENT FORM

Etu Pasifika Auckland

1/627 Mt Wellington Highway, Mt Wellington
Phone: 09 276 8640 | Email: info.epa@etupasifika.co.nz GP: Etu Auckland | NZMC: 00627 | EDI: mwllacfm

Fields with * are compulsory	Anyone over age of 16 years must complete their own enrolment form	***NHI (Office use only)**

***Name**	Title	First Name(s)	Family Name	Other Names Known (eg. Maiden Name etc)
***Birth details**	Date of Birth ______/______/______ Day Month Year	Place & Country of Birth	***Gender**	☐ Male ☐Female ☐Gender Diverse (Please state:)

***Usual Residential Address**	Street Number	Street Name	Suburb	City/Town Postcode
Postal Address *(if different from above)*	Street Number	Street Name	Suburb	City/Town Postcode

***Contact details**	Mobile Number	Home Phone	Email Address	
***Emergency Contact**	Full name of person to contact	Address	Phone number	Relationship
***Employer Details**	Employer name	Employer Address	Employer Phone Number	Occupation

Transfer of Records	*To get the best care possible, I agree to the Etu Pasifika Auckland 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	☐ Not Applicable
	Previous Practice Name	Previous Practice Email, Phone/Fax Number

***How did you hear about us?**	☐ NZ Rugby League	☐ Word of Mouth	☐ Online Search	☐ Other

***Ethnicity Details** Which ethnic group(s) do you belong to? *Tick the space or spaces which apply to you*	☐ NZ European ☐ Maori Iwi: ☐ Samoan ☐ Cook Islands Maori ☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian ☐ Other such as Dutch, Japanese, Tokelauan, Fijian Please state:	**High User Health Card**	☐ Yes	☐ No
		Card Number	Card Expiry Date	
		Community Services Card	☐ Yes	☐ No
		Card Number	Card Expiry Date	

Enrolment in the Practice/Primary Health Organisation (PHO)

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
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
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.

My agreement to the enrol 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 this practice I will be included in the enrolled population of the Primary Health Organisation this practice belongs to, 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. (ProCare Health Ltd. Level 2, 110 Stanley Street, Grafton Ph.09-3777827 www.procare.co.nz)

I have read and I agree with the Use of Health Information Statement which also includes information on the security and privacy of data that is collected. 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.

*SIGNATURE	*DATE
	______/______/_______ Day Month Year

OR Signed by AUTHORITY: an authority is the legal right to sign for another person if 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

*Office Use Only	NES	Trans in.	Alerts	NOK	Scanned	Checked by: