


<b>East Coast Bays Doctors</b>	<b>ENROLMENT FORM</b> 512 East Coast Rd, Windsor Park, Auckland 0630 P: 09 478 9600 F: 09 475 6143 EDI: ecbdwind	

<b>Provider: GP2GP:</b> <input type="checkbox"/> Dr Gee Wong #28995 <input type="checkbox"/> Dr Monique Huerta #15770 <input type="checkbox"/> Dr Tanja Minic #37688 <i>(please tick doctor which you prefer)</i>	NHI (Office use only)
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<b>Legal Name</b> (Title)	Given Name	Middle Name(s)	Family Name
<b>Other Name(s)</b> (eg. maiden name /preferred name)			
<b>Birth Details</b>	Day / Month / Year of Birth	Place of Birth	Country of birth
<b>Gender</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)
<b>Optional</b>	Marital status	Occupation	

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

<b>Contact Details</b>	Mobile Phone	Home Phone	Email Address
<b>Emergency Contact /NOK</b>	Name	Relationship	Mobile (or other) Phone

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

<b>Transfer of Records</b>	<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, as I am only able to be enrolled at <u>ONE</u> practice at a time in NZ</i>		
	<input type="checkbox"/> YES, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor, Practice & Address		SIGNATURE:..... DATE:.....

<b>Ethnicity Details</b> 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 <input type="radio"/> Maori <input type="radio"/> Samoan <input type="radio"/> Cook Island Maori <input type="radio"/> Tongan <input type="radio"/> Niuean <input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state <input type="text"/>	<b>Primary Language Spoken:</b> IWI <b>Smoking status (if over 15)</b> Never smoked <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Stopped: Greater than 15months <input type="checkbox"/> Less than 12 months <input type="checkbox"/> Current smoker <input type="checkbox"/> Would you like support to quit?      Yes <input type="checkbox"/> No <input type="checkbox"/>
		<input type="checkbox"/> I authorise East Coast Bays Doctors to contact me via text message <input type="checkbox"/> I authorise East Coast Bays Doctors to contact me via email (non-secure)

## 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 and have provided proof of my eligibility** (If yes, tick box and proceed to Agreement to Enrol)

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"/>

<b>PROOF OF ELIGIBILITY</b> PASSPORT..... VISA.....	<input type="checkbox"/>	Evidence sighted (office use only).....
<b>OTHER DOCUMENTATION</b> .....	<input type="checkbox"/>	Evidence sighted (office use only).....

## 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 East Coast Bays Drs I will be included in the enrolled population of Comprehensive Care & 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>	<input type="checkbox"/>	<input type="checkbox"/>
Signature	Day / Month / Year	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.**

<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)		