

Practice name: **ROSELANDS DOCTORS**

Phone number: **09 298 7504**

Address: **13 O'SHANNESSEY ST.
PAPAKURA 2110**

EDI number: **ROSELDDR**
Fax number: **09 298 9078**

Title		Surname		NHI	
Mr Mrs Ms Miss Dr				First Name(s)	
Preferred name				Other names known by (e.g. maiden name)	
Gender		Male <input type="checkbox"/> Female <input type="checkbox"/>		Date of birth	
				____ / ____ / ____ day month year	
Physical address		Street or rapid (rural) number	Name of street	Place of birth	
				City/Town	
		Suburb		Country	
		City/Town	Postcode	Community Services Card	
				<input type="checkbox"/> YES	
				<input type="checkbox"/> NO	
		Country		Card number	
				Expiry date	
Postal address				High User Health Card	
				<input type="checkbox"/> YES	
				<input type="checkbox"/> NO	
				Card number	
				Expiry date	
Contact details		Day phone	Night phone	Cell phone	Email
Occupation					
Emergency contact (in case of emergency)		Name of person to contact	Relationship	Phone number	Other contact details

Which ethnic group do you belong to?

<input type="checkbox"/> 11 New Zealand European/Pakeha	<input type="checkbox"/> 12 Other European	<input type="checkbox"/> 21 NZ Māori. Name of iwi:			
<input type="checkbox"/> 31 Samoan	<input type="checkbox"/> 32 Cook Island Māori	<input type="checkbox"/> 33 Tongan	<input type="checkbox"/> 34 Niuean	<input type="checkbox"/> 35 Tokelauan	<input type="checkbox"/> 36 Fijian
<input type="checkbox"/> 37 Other Pacific	<input type="checkbox"/> 41 South East Asian	<input type="checkbox"/> 42 Chinese	<input type="checkbox"/> 43 Indian	<input type="checkbox"/> 44 Other Asian	<input type="checkbox"/> 51 Middle Eastern
<input type="checkbox"/> 52 Latin American	<input type="checkbox"/> 53 African	<input type="checkbox"/> 54 Other			

Transfer of records: 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.

Yes No Not applicable Doctor's name: _____

Address/location: _____

Dependants listed on this form will also be enrolled in the PHO as long as I am legally entitled to sign on their behalf (see over)

NHI	First names	Family name	Gender	Ethnicity/ethnicities	Date of birth

Enrolment in the practice / Primary Health Organisation (PHO)

I intend to use _____ as my regular and ongoing provider of general practice / GP / First Level primary health care services.

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 OR
- b. I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) OR
- 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 OR
- 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) OR
- e. I am an interim visa holder who is eligible immediately before my interim visa started OR
- 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 OR
- 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 OR
- 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 OR
- i. 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) OR
- j. I am participating in the Ministry of Education Foreign language Teaching Assistantship scheme OR
- k. I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund.

I confirm that, if requested, I can provide proof of my eligibility.

My agreement to the enrolment process NB Parent or caregiver to sign if you are under 16 years

I choose to enrol with this practice as my regular and on going provider of general practice / GP / First Level primary health care services.

I understand that by enrolling with this practice I will be enrolled with the Primary Health Organisation (PHO) this practice belongs to, and my name, address and other identification details will be included on both the Practice and the PHO Enrolment Register.

I understand that if I visit another 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 with the PHO, and their contact details.

I have read and I agree with the Health Information Privacy Statement in accompanying PHO information booklet.

I agree to inform the practice of any changes in my eligibility.

day month year

SIGNATURE

DATE

OR Signed by authority*

Full name of authority

Contact phone number

Relationship

Address

Signature of authority

day month year

Detail the basis of authority (e.g. parent of a child under 16):