



## ENROLMENT FORM

The doctors quaymed Wynyard  
58 Gaunt Street, Wynyard  
Quarter

Ph: 09 930 9980 F: 09 930 9989  
E: wynyard@quaymed.co.nz

Fields marked with an \*  
are compulsory

EDI: quaypark  
GP2GP: Dr Karen Napier  
MCNZ 37281

\*NHI (Office use only)

|                      |                                   |                                     |  |                   |
|----------------------|-----------------------------------|-------------------------------------|--|-------------------|
| <b>Name</b>          | (Title)                           | *Given Name                         | * Other Given Name(s)                                      | * Family Name     |
| <b>Birth Details</b> | * Day / Month / Year of Birth     |                                     | *Place of Birth  | *Country of birth |
| <b>Gender</b>        | <input type="checkbox"/><br>*Male | <input type="checkbox"/><br>*Female | <input type="checkbox"/><br>*Gender diverse (please state) |                   |
| <b>Occupation</b>    | Company Name                      |                                     | Occupation   |                   |
|                      | Company Address                   |                                     | Work Phone   |                   |

|  |   |                        |                           |
|--|---|------------------------|---------------------------|
| <b>Usual Residential Address</b>                   | *House (or RAPID) Number and Street Name      | *Suburb/Rural Location | *Town / City and Postcode |
| <b>Postal Address</b><br>(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  |
| 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 |
| 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 |
| <b>Emergency Contact</b>  | Name         | Relationship | Mobile (or other) Phone                                  |

**Transfer of Records** I agree to [Practice Name] obtaining my records from my previous doctor, which will mean I will be removed from their practice register.

|   |   |           |
|---|---|-----------|
| <input type="checkbox"/> Yes, please request transfer | <input type="checkbox"/> Not applicable | Signature |
| Previous Doctor and/or Practice Name and Address      |   | Date      |

|   |   |                    |
|---|---|--------------------|
| <p><b>*Ethnicity Details</b><br/>Which ethnic group(s) do you belong to?<br/><i>Tick the space or spaces which apply to you</i></p> | <input type="radio"/> New Zealand European<br><input type="radio"/> Maori<br><input type="radio"/> Samoan<br><input type="radio"/> Cook Island Maori<br><input type="radio"/> Tongan<br><input type="radio"/> Niuean<br><input type="radio"/> Chinese<br><input type="radio"/> Indian<br><input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state<br><input type="text"/><br><input type="text"/> | <b>Iwi:</b>        |
|   |   | <b>Hapu:</b>       |
|   | <b>Community Services Card Number</b>   | <i>Expiry Date</i> |
|   | <b>High User Health Card Number</b>   | <i>Expiry Date</i> |
|   | <p><b>Smoking status (if over 15)</b><br/> <input type="checkbox"/> Never smoked <input type="checkbox"/> Ex-smoker - <input type="checkbox"/> Greater than 15months<br/> <input type="checkbox"/> less than 12 months <input type="checkbox"/> Current smoker</p>  |                    |
|   | <p><b>If you are a current smoker or have recently quit, we would like to help you stop to improve your health. Would you like help to stop/stay an ex-smoker?</b><br/> <input type="checkbox"/> Would you like support to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>   |                    |

## My declaration of entitlement and eligibility

|   |                          |
|---|--------------------------|
| <b>I am entitled to enrol</b> because I am residing permanently in New Zealand.<br><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> | <input type="checkbox"/> |
|---|--------------------------|

**I am eligible to enrol** because:

|   |   |                          |
|---|---|--------------------------|
| a | <b>I am a New Zealand citizen</b> <i>(If yes, tick box and proceed to I confirm that I can provide proof of my eligibility below)</i> | <input type="checkbox"/> |
|---|---|--------------------------|

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>I confirm</b> that I can provide proof of my eligibility | <input type="checkbox"/> | Evidence sighted <i>(Office use only)</i> |
| My work/student/visitor/other visa is valid for a 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 the [Practice Name] I will be included in the enrolled population of National Hauora Coalition PHO, 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"/> | <input type="checkbox"/> |
|                          |           |                    | 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><br><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) |              |               |