Patient Enrolment Form

Aramoho Health Centre, 144 Somme Parade, Whanganui 4500
Ph: (06) 343 9050 Email: admin@aramohohealth.co.nz GP2GP: aramohoh

***Mandatory to complete**

Doctor: _____ NZMC: _____ **Title**: ☐ Miss ☐ Master ☐ Other please specify_____

***Family Name**: _____ NHI: _____

***First Name**: _____ Preferred Name: _____

***Middle Name** (s): _____ Other Names known by _____

***Date of Birth**: _____/_____/_____ Pronouns: _____ ***Country of Birth**: _____

***Place of birth**: _____ ***Gender**: _____ ***Gender at Birth if different**: _____

***Address** Street: _____ ***Suburb**: _____

***City**: _____ ***Postcode**: _____ ***Postal address if different**: _____

***Home phone**: _____ ***Mobile**: _____

***Email**: _____

Would you like your child linked to your Manage My Health Patient portal? ☐ Yes ☐ No

Do You Have a Community Services Card ☐ Yes ☐ No Is your Child linked to your card ☐ Yes ☐ No

***Parent/Guardian Name**: _____ ***Relationship to child**: _____

*** Address**: _____ ***Parent/Guardian Phone**: _____

Parent/Guardian Name: _____ Relationship to child: _____

Address: _____ Parent/Guardian Phone: _____

***Ethnicity** – which ethnic group(s) do you belong to? (Tick the box or boxes which apply to you):

☐ NZ European ☐ Māori ☐ Samoan ☐ Cook Island Māori

☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian

☐ Other (such as Dutch, Japanese, Tokelauan) Please state: _____

If you would like to state your iwi, please do so here: _____

Transfer of Records from Another Practice

***Transfer of Records** – In order to get the best care possible, I agree to the practice obtaining records from my previous practice, I understand that I will also be removed from the register of my previous practice:

☐ Yes, please request transfer of my records ☐ No, please do not request transfer of my records ☐ Not applicable.

Name of Previous Practice/Doctor: _____

Address of Previous Practice/Doctor: _____

P.T.O

***Signed**: _____ ***Date**: _____

My Declaration of Entitlement and Eligibility to Enrol

***I am entitled to enrol because I live in New Zealand, and I am eligible to enrol because I meet one of the following eligibility criteria (tick the box which applies to you):** **Please Tick**

a)	I am a New Zealand citizen	☐
b)	I hold a resident visa or a permanent resident visa (for 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 intent 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 **OR** in the control of the Chief Executive of the Ministry of Social Development	☐
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	☐

Agreement to the Enrolment Process

I intend to use Aramoho Health Centre as my regular and on-going provider of general practice /GP / healthcare services.
I understand that the Primary Health Organisation (PHO) that this practice is affiliated to is the Whanganui Regional Health Network (WRHN).
I understand that by enrolling with Aramoho Health Centre I will be included in the enrolled population of WRHN and my name, address and other identification details will be included on the practice, WRHB 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 WRHN provides, along with the WRHN'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 this 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 confirm that, if requested, I can provide proof of my eligibility to enrol.
I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

If signed by Authority (Patient is under 16 or unable to sign this form) please provide the following:

***Signed:** _____ ***Date:** ____/ _____/ _____

***Full name of Authority:** _____ ***Relationship:** _____

*** Address of Authority:** _____ *** Phone Number:** _____

***Signed:** _____ ***Date:** ____/ _____/ _____

***Full name of Authority:** _____ ***Relationship:** _____

***Address of Authority:** _____ ***Phone Number**: _____