FOR OFFICE USE ONLY **NHI:** **ENTERED/COMPLETED BY:** (staff initials)

☐ *Photo ID and Address sighted* ☐ *NES Enrolment* ☐ *Smoking status entered* ☐ *Welcome text sent*

☐ *Notes transfer requested* ☐ *Tx Screening* ☐ *Scanned* ☐ *Welcome letter sent (Outbox)*

ENROLMENT FORM

WaihiFamilyDoctors

National Hauora Coalition

Physical Address: 43 Kenny Street, Waihi 3610
Postal Address: PO Box 262, Waihi 3641
Phone: (07) 863 2112
Email: reception@waihifamilydoctors.co.nz
EDI: waihidoc (Dr Tineke Iversen 28635)

*** Indicates fields that are COMPULSORY**

Name	Title	First Name*	Surname/Family Name*	
	Middle Name		Preferred Name	Maiden Name
Birth Details	Day/Month/Year*		Place of Birth*	Country of Birth*
Gender	☐ Male	☐ Female	☐ Gender Diverse (please specify)*	

Usual Residential Address	House Number and Street Name*	Suburb/Rural Delivery*	Town/City and Postcode*
Postal Address *(if different from above)*	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town/City and Postcode
Contact Details*	Home Phone	Mobile Phone	
	I consent to receiving text messages ☐ Yes ☐ No		
Email Address			

Next of Kin / Emergency	Name*	Relationship*	Mobile (or other) Phone*

Ethnicity Details*

Which ethnic group(s) do you belong to?

Tick the space(s) which apply to you

☐	New Zealand European
☐	Maori
☐	Samoan
☐	Cook Island Maori
☐	Tongan
☐	Indian
☐	Other (please state)

Occupation

Employer

Employer Address

Smoking Status* (applies to 15 years of age and over)

☐ Never smoked ☐ Ex-Smoker ☐ Current Smoker ☐ Vaping

If you are a current smoker and/or vaper, would you like support to quit?

☐ Yes ☐ No

Preferred Pharmacy

☐Clarks ☐Barrons ☐Waihi Beach Chemist ☐Katikati Unichem

☐Other (please state) _____

Transfer of Records

In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I understand that I will be removed from their practice register, as I am only able to be enrolled at one practice at a time in New Zealand. I agree to obtain and provide my own medical records if enrolling from outside of New Zealand

☐ **Yes**, please request my transfer of records ☐ **No** ☐ Not Applicable (e.g. new born baby)

Previous Doctor and/or Practice Name

Practice Address / Location

Patient Portal – My Indici

I would like to sign up to My Indici to access my records online. ☐ Yes ☐ No

Please note: you will need your own individual email address to access this service.
MyIndici is not available to patients under the age of 16

I intend to use **Waihi Family Doctors** 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:

Please tick the option that applies ☑

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 was 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 I have provided 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 National Hauora Coalition, 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.
- I agree to inform the practice of any changes in my eligibility.
- I have read and agree to Waihi Family Doctor's enrolment policy, Waihi Family Doctors New Patient Information Pack and have had opportunity to ready the Waihi Family Doctors Health Information Privacy Statement.
- I agree to make payment at the time of my consultations and accept liability for collection costs of unaddressed debt
- I understand that AI may be offered during consultations, but I have the right to decline this without impact to my care

	/ /
SIGNATURE	**DATE**

If signed by AUTHORITY (under 16 years) -

Full Name of Authority	Contact Phone Number	Relationship
Detail the basis of authority (e.g. parent of a child under 16):		