HAURAKI PHO

WaihiFamilyDoctors

☐ Dr Tineke Iversen NZMC 28635 ☐ Dr Andy Gibson NZMC 39273

☐ Dr Andy von Biel NZMC 13096 ☐ Dr Jess Ussher NZMC 72878

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Phone (07) 863 2112 Fax (07) 863 2112 EDI: waihidoc

Title	Mr Mrs Ms Miss	**First Name(s)**		**Family Name**	
Preferred Name				**Other Names (eg. Maiden name)**	
Gender	☐ Male ☐ Female			**Place & Country of Birth**	
Physical Address	**No.**	**Name of Street**		**Date of Birth**	_____/_____/_____ Day Month Year
	Rural No./Suburb			**Community Services Card**	**Card No. 00000 -** _____ **Expiry Date :** _____ / _____ / _____
	City/Town	**Postcode**		**Gold Card**	**Card No.** _____ **Expiry Date :** _____ / _____ / _____
Postal Address (if different)	**P.O Box/Other**			**High User Health Card**	**Card No.** _____ **Expiry Date :** _____ / _____ / _____
Smoking Status (Circle one)	**Never Smoked Ex Smoker Current Smoker** **If you are a smoker would you like help to stop Yes/No**				
Your Contact Details	**Day Phone**	**Night Phone**	**Cell Phone**	**We will send you txt messages to remind you of appointments and provide information. Please tick here if you DO NOT wish to receive txt messages.** ☐	
Emergency contact	First Name Last Name	Relationship	Phone Number/s	**Your NHI Number (if known)**	

Which ethnic group do you belong to? Tick the space or spaces which apply to you		**Photographic Proof of identification (only patients over 16 years old)**	**Proof of Address**
New Zealand European		**ID Type:** **ID No.**	**Attached -** ☐ **Yes** ☐ **No**
Maori			
Samoan		**Transfer of Records**	
Cook Island Maori		**In order to get the best care possible, I agree to the Practice to obtain my records from my previous Doctor. I understand that I will be removed from their practice register.**	
Tongan			
Indian		☐ **Yes** ☐ **No** ☐ **Not Applicable (e.g. new born baby)**	
Other (Please state)		**Practice Name:** **Suburb/City:** **Doctor:** **Phone No. :**	

Manage My Health – Patient Portal	**Would you like access to your GP records online?** ☐ **Yes** ☐ **No** ☐ **Already Registered**
Patient Survey	From time to time the Ministry of Health may contact you and ask for your feedback on your experience of care provided by our practice. This information used by the Ministry of Health to improve services to patients. Participation is voluntary and anonymous. The Ministry will contact you via an email address. **Please enter your email address here:** _____@_____ Or Tick here if you do not wish to participate in this survey. ☐

Enrolment in the Practice / Primary Health Organisation (PHO)

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, if requested, I can provide proof of my eligibility. YES/NO

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 Hauraki Primary Health Organisation (HPHO), 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.

	/ /
SIGNATURE	**DATE**

OR Signed by AUTHORITY[1]

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):		

An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.