Onewa Doctors Enrolment Form

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comprehensive care

Dr Elvira Nario-Anderson *NZMC # 34654* **Dr Virgilio Beltran** *NZMC # 57971*	**Administration Use Only**	
	NHI:	Date:
	Chart Number:	Staff Code:

Legal Name*	Title	Given Name	Middle Name(s)	Family Name
Other Name(s) *(e.g. maiden name /preferred name)*				
Birth Details*		Day / Month / Year	Place of Birth (Town)	Country of Birth
Gender*	☐ Male	☐ Female	☐ _____ Gender Diverse (please state)	Marital Status
Additional Details	Religion	Insurance	Company Details*	Occupation*

Usual Residential Address*	House (or RAPID) Number and Street Name	Suburb/Rural Location	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*	Mobile Phone: Home Phone:		Email Address	
Emergency Contact /Next of Kin*	Full Name	Contact Number	Address	Relationship

Community Services Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number
High User Health Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number

Ethnicity Details*

(Which ethnic group(s) do you belong to?)

(Tick the space or spaces which apply to you)

☐ New Zealand European
☐ Māori
☐ Samoan
☐ Cook Island Māori
☐ Tongan
☐ Niuean
☐ Chinese
☐ Indian
☐ Filipino
☐ Other(s) (*state below)*
_____
_____
_____
_____
_____

Primary Language Spoken	**Iwi**

Alcohol Consumption	**Smoking Status*** *(For patients over 15 years old)*	**Food or Medication Allergies*** *(If there are any please specify)*
Quantity per Week: _____ Type(s) of Alcohol: _____ _____ ☐ Nil	☐ Never smoked ☐ Ex-smoker Stop Date: _____ ☐ Current smoker Would you like support to quit smoking? ☐ Yes ☐ No	_____ _____ _____ _____ _____ _____ ☐ Nil

☐ I authorise Onewa Doctors to contact me via text message
☐ I authorise Onewa Doctors to contact me via email (non-secure)

Transfer of Medical Records and Information*	*In order to get the best care possible, I agree to the General Practice of Onewa Doctors obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register, as I am only able to be enrolled at 1 practice at a time in New Zealand.*		
	☐ Yes, please request transfer of my records	☐ No transfer	☐ Not applicable
	Previous Doctor and/or Practice Name	Previous Practice Address/Location	

My declaration of entitlement and eligibility*

I am entitled to enrol because I am residing permanently in New Zealand. *(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 am eligible to enrol because:

a	**I am a New Zealand citizen** *(If yes tick box and proceed to '**I confirm that, if requested, I can provided proof of my eligibility**' below)*	☐

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)	☐
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	☐
d	I have a work visa/permit and can show that I am legally 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	☐

I confirm that, if requested, I can provide proof of my eligibility	☐	Evidence sighted (*Office use only*)

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

I intend to use Onewa Doctors as my regular and on-going provider of general practice / GP / health care services.

I understand that by enrolling with Onewa Doctors I will be included in the enrolled population of this practice's Primary Health Organisation (PHO) Comprehensive Care, 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 or informed 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 understand 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.

Signatory Details*	Signature	Day / Month / Year	☐ 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.

Authority Details* *(where signatory is not the enrolling person)*	Full Name	Relationship	Contact Phone
	Legal basis of authority (e.g. parent of a child under 16 years of age)		