TE KOROWAI HAUORA O HAURAKI

0508 835 676 | PO Box 605 Thames 3540 | www.korowai.co.nz

HAURAKI PHO HAURAKI PRIMARY HEALTH ORGANISATION NETWORK

Enrolment Form

NHI	

Title (Circle one)	Miss	Ms	Mrs	Mx	Mr	Other
Surname						
First Name(s)						
Middle Name			**Other Names Known By**			
Preferred Name			**Place of Birth**			
			Country of Birth			
Date of Birth	/ /		**Would you like to register with Manage My Health?** (Tick one)		☐ Yes	☐ No
Physical Address						
	House (Or Rapid) Number & Street Name		Suburb / Rural Location		Town / City & Postcode	
Postal Address (If different from above)						
	House Number & Street Name or PO Box Number		Suburb / Rural Location		Town / City & Postcode	
Email Address						
Phone Numbers						
	Day Phone Number		Evening Phone Number		Mobile Number	
Gender (Tick one)	Female ☐	Male ☐	Gender Diverse (Please state)			
Smoking / Vaping Status (Tick one)	☐Never (Smoked or Vaped)	☐Ex Smoker	☐Current Smoker	☐Current Vaper	☐Ex Vaper	
Emergency / Next of Kin Contact						
	Name of Contact Person	Relationship to you	Phone Number	Address		
Occupation / Job Title		**Employer Name**				
Address		**Phone Number**				

Which Ethnic group do you belong to? (please tick as many as are applicable)

Māori ☐	NZ European ☐	Indian ☐	Cook Island Māori ☐	Niuean ☐	Chinese ☐	Tongan ☐	Samoan ☐
Other ☐ (please state):							

Please tick which is your preferred Whānau Health Centre:

Thames ☐	**Paeroa** ☐	**Coromandel** ☐	**Whitianga** ☐
210 Richmond St PO Box 605 Thames 3450 Ph: 07 868 0033 thames@korowai.co.nz **GP Medical Council No. 45522:** Dr William Stirling	15 Princes St Paeroa 3600 Ph 07 862 9284 paeroa@korowai.co.nz **GP Medical Council No. 72437:** Dr Hilda Malibin	225 Kapanga Road Coromandel 3506 Ph 07 866 8084 coromandel@korowai.co.nz **GP Medical Council No. 62099:** Dr Hinetamatea Mikaere	2 Coghill Street Whitianga 3510 Ph: 07 869 5244 whitianga@korowai.co.nz **GP Medical Council No. 169967:** NP Ashleigh Battaerd

GP Notes Transfer: (GP2GP address: tkorowai) NOTE: we do not accept hard copies.

See page 2 - for Eligibility, Consent, and Signature.

NHI	

Previous Clinic Details			
Clinic Name		**Phone No.**	
Address			

Transfer of Records

In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register.

I understand that transferring my medical records indicates that I will no longer be registered with my previous GP. Yes ☐ No ☐ N/A ☐

I intend to use Te Korowai Hauora o Hauraki as my regular and on-going provider of General Practice / GP / First Level Primary Health Care Services.	☐ Yes	☐ No

My Declaration of Entitlement and Eligibility

I am entitled to enrol because I am residing permanently in New Zealand and meet one of the following criteria:
(The definition of residing permanently in New Zealand 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: *(please tick which option 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*** **Visa Sighted Yes / No**	
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 New Zealand Aid Programme student studying in New Zealand 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 New Zealand 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 old

- ✓ 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.
- ✓ I choose to enrol with this practice as my regular and ongoing 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 Primary Health Organisation (PHO) this practice belongs to, 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 am aware that a mobility toilet may not be available at my practice, and I will discuss my needs with staff as required.

Signature: _____ **Date:** _____

OR signed by designated signatory who is able to sign on behalf of client (i.e. Parent/Guardian of child under 16 years of age)

Full name of signatory:		**Relationship to client:**	
Address:		**Phone number:**	

I consent to receiving text messages (please tick)	☐ Yes	☐ No	**I consent to receiving emails for health promotional services only** (please tick)	☐ Yes	☐ No
I would like to receive the Te Korowai Hauora o Hauraki Newsletter via email				☐ Yes	☐ No
My email address to send the Te Korowai Hauora newsletter:					