



Fields marked with an * are compulsory Fill own form if 16yrs or over For under 16yrs, please request a child form	<b>EDI: UCSAYQDY</b>	*NHI (Office use only)
	<input type="checkbox"/> Dr Mohamed Bahr <input type="checkbox"/> Dr Shujaullah Kamali	NZMC#: 29904 NZMC#: 25793

<b>Name</b>	(Title)	*Given Name/First Name	*Other Given Name(s)	*Family Name/Surname	
<b>Birth Details</b>		*Day / Month / Year of Birth	*Place of Birth	*Country of birth	
<b>Gender</b>	<input type="checkbox"/> *Male	<b>*Contact Details</b>	<b>Mobile No.</b>		
	<input type="checkbox"/> *Female		<b>Home Phone</b>		
	<input type="checkbox"/> *Gender diverse (Please state)		<b>Email Address</b>		
<b>*Next of Kin/ Emergency Contact</b>	Name		Relationship		
	Mobile: _____ Phone: _____		Email: _____		
Do you consent to the practice sending TEXT messages for the purpose of recalls, surveys & updating your details?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you consent to the practice sending EMAILS for the purpose of recalls, surveys & updating your details?				Yes <input type="checkbox"/>	No <input type="checkbox"/>

<b>Usual Residential Address</b>	*House (or RAPID) Number and Street Name	*Suburb/Rural Location
	*Town / City	*Postcode
<b>Postal Address</b> (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Location
	Town / City	Postcode

<b>*Ethnicity Details</b> Which ethnic group(s) do you belong to?	<b>Tick the space or spaces which apply to you</b>				
	<input type="checkbox"/> New Zealand European	<input type="checkbox"/> Māori	<input type="checkbox"/> Samoan	<input type="checkbox"/> Cook Island Maori	<input type="checkbox"/> Tongan
	<input type="checkbox"/> Niuean	<input type="checkbox"/> Asian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Indian	<input type="checkbox"/> American
	<input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan). Please state _____				
	<b>Iwi:</b>		<b>Hapū:</b>		

<b>*Alcohol Consumption</b>	<input type="checkbox"/> Non	<input type="checkbox"/> Social	<input type="checkbox"/> Heavy
<b>*Smoking Status</b> (if over 15)	<input type="checkbox"/> Never smoked	<input type="checkbox"/> Ex-smoker - <input type="checkbox"/> Greater than 15months (Approximate quit date _____)	
	<input type="checkbox"/> Current smoker	<input type="checkbox"/> less than 12 months	
<b>If you are a current smoker or have recently quit, we would like to help you stop to improve your health.</b>			
<b>Would you like help to stop/stay an ex-smoker?</b>			
	<input type="checkbox"/> Would you like support to quit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Occupation</b>	Company Name	Title/Occupation
	Company Address	Work Phone

<b>Community Service Card</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Card Number	Expiry Date
<b>High User Health Card</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Card Number	Expiry Date
<b>Southern Cross Insurance Card</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Card Number Policy Number	Expiry Date
<b>Manage My Health</b>	Would you like to sign up to Manage My Health? <input type="checkbox"/> Yes <input type="checkbox"/> No		Each person that uses the portal must have their own unique email address.



<b>*Transfer of Records</b>	I agree to Rototuna Family Health obtaining my records from my previous doctor, which will mean I will be removed from the previous practice register.		
	<input type="checkbox"/> Yes, please request transfer	<input type="checkbox"/> Not transfer	Signature
<input type="checkbox"/> I have never seen a GP in NZ before	<input type="checkbox"/> Not Applicable	Date	
Previous Doctor and/or Practice Name and Address			(Office use only)

## 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 I can provide 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)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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 <b>OR</b> in the control of the Chief Executive of the Ministry of Social Development	<input type="checkbox"/>
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)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>

<b>I confirm</b> that I can provide proof of my eligibility	<input type="checkbox"/>	Evidence sighted ( <i>Office use only</i> )
My work/student/visitor/other visa is valid for a period of	Year(s):	Expiry Date:

## My Agreement to the Enrolment Process

**NB. Parent or Caregiver to sign if you are under 16 years**

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

**I understand** that by enrolling with the **Rototuna Family Health Centre** I will be included in the enrolled population of National Hauora Coalition PHO, 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** 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 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 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 understand** that appointments must be paid on the day, and outstanding accounts will be transferred to Marshall Freeman Debt Collectors. Terms and Conditions apply.

<b>Signatory Details</b>	Signature	Day / Month / Year	<input type="checkbox"/>	<input type="checkbox"/>
			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.**

<b>Authority Details</b> (where signatory is not the enrolling person)	Full Name:	Relationship	Contact No.
	Basis of Authority (eg: Parent of a child under 16 years of age)		