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| **Chadwick Healthcare**  **Greerton, Tauriko, Bethlehem** | | | **Office Address: 120 Chadwick Rd, Greerton, Tauranga**  **Ph:** 07 579 0144 **Fax:** 07 579 0151 | |
| **C T B** | **Provider** | **NZMC** | **EDI: chadwic** (GP to GP Electronic File Transfer) | **NHI** |

**Fields above for Office Use ONLY**

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| **Legal Name** | Title | | Surname/Family Name | | First/Given Name | |
| Middle Name(s) | | | Preferred Name | | Maiden Name |
| **Birth Details** | |  | |  | |  |
| Day / Month / Year of Birth | | Place of Birth | | Country of Birth |
| **Gender** | |  Male  Female Gender diverse (please state) | | | | Primary Language |

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| **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 | |

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| **Next Of Kin / Emergency Contact** | Name | Relationship | Mobile (or other) Phone |
| Address | | |

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| **Community Services Card** |  |  |  |  |
| Yes | No | Day / Month / Year of Expiry | Card Number (if known) |
| **High User Health Card** |  |  |  |  |
| Yes | No | Day / Month / Year of Expiry | Card Number (if known) |

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| **Ethnicity Details**  Which ethnic group(s) do you belong to?  ***Tick the space***  ***or spaces which apply to you*** | New Zealand European  Maori  Samoan  Cook Island Maori  Tongan  Niuean  Chinese  Indian  Other (such as Dutch, Japanese, Tokelauan).  Please state: | **IWI** |  |
| **Occupation** |  |
| **Employer & Address** |  |
| **Smoking Status ( applies to 15 years & over ONLY)**  Never smoked 🞎 Current smoker 🞎  Ex-smoker 🞎 Approximate Quit Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Would you like support to quit? Yes 🞎 No 🞎 | |
| **Consent to Receive Communications via *Email - Text - Patient Portal (if available)***  *Please tick applicable boxes to give your consent:*   Text Message Manage My Health - Patient Portal (secure)   Email (non-secure) | |

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| **Transfer of Records Authority** | *In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor.*  *I understand I will be removed from their practice register, as I am only able to be enrolled at 1 practice at a time in NZ.* | |
|  Yes - please request transfer of my records   Not Applicable  No | Previous Doctor and/or Practice Name |
|  |  |
| Signature Day / Month / Year | Practice Address / Location |

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| **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:

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| a | **I am a New Zealand citizen** *(If yes, tick box and proceed to* ***I confirm that, if requested, 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:

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| --- | --- | --- | --- | --- | --- |
| 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 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 I have provided proof of my eligibility | |  | Evidence sighted (*Office use only*) | |

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| **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 Chadwick Healthcare I will be included in the enrolled population of **Western Bay of Plenty** **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 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 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 agree to the Terms and Conditions of Trade of Chadwick Healthcare and undertake to** pay any fees applicable for Practice Services & all costs incurred in collection of any debt for myself & my dependents.

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| **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.***

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