CARING CLINIC DOCTORS ENROLMENT FORM

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				*NHI	
Title		*First Name(s)		*Family Name	
Preferred Name				*Date of Birth	_____/_____/_____ Day Month Year
*Gender	☐ Male ☐ Female ☐ Gender Diverse (please state)			*Place & Country of birth	
*Physical Address	Street number	Name of Street		Occupation	
	Suburb			*High User Card Card Number & Expery Date	YES / NO
	City/Town	Postcode			
Postal Address	☐ tick if same as above			Community Services Card Card Number	YES / NO
Contact Details	Day Phone	Night Phone		*Mobile No ☐ (Tick box to accept txts)	*Email ☐ (Tick box to accept emails)
*Emergency contact	Name of person to contact			Relationship	Phone number

*Which ethnic group do you belong to? Tick the space or spaces which apply to you	*Smoking Status	*Eligibility *(see over page)* I confirm that, if requested, I can provide proof of my eligibility I agree to inform the practice of any changes in my eligibility	
☐ 11 New Zealand European	☐ Current	*Eligible under criteria (enter applicable letter from list over page)	*
☐ 21 Māori Iwi:	☐ Ex-Smoker	**I have read and agree to the Enrolment Process, the Health Information Privacy Poster/Statement, and Patient Experience Survey(tick).**	*
☐ 31 Samoan			
☐ 32 Cook Islands Maori	☐ Never Smoked	☐ **Not Eligible** (Tick if not eligible under any criteria over page)	
☐ 33 Tongan			
☐ 34 Niuean	*Transfer of Records ☐Yes ☐No ☐Not applicable		
☐ 35 Tokelauan	In order to get the best care possible, I agree to the transfer of my records from my previous Doctor. I understand, I will be removed from their practice register.		
☐ 42 Chinese	**Doctor's Name**		
☐ 43 Indian	**Address / Location:**		
☐ 54 Other such as DUTCH, JAPANESE Please state:	**Phone/Fax:**		

*SIGNATURE	*DATE
	/ / Day Month Year

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

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):		

Please read and identify on your enrolment form which criteria provides your eligibility to funded health services