



TE KĀIKA HEALTH ENROLMENT FORM

25 College Street,
Dunedin
Ph: 03 455 2721
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reception@tekaika.nz



GP2GP: Dr
MC No:
EDI: forbury

NHI (Office use only)

*Name	(Title)	Given Name	Other Given Name(s)	Family Name
	*Birth Details		Day / Month / Year of Birth	Place of Birth
*Gender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occupation
	Male	Female	Gender diverse (please state)	

*Usual Residential Address	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
Postal Address <small>*(if different from above)</small>	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	Name	Relationship	Mobile (or other) Phone

Employer Details	Company	Phone	Address
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*Transfer of Records	<i>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>		
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	*Previous Doctor and/or Practice Name		Address / Location

*Ethnicity Details <small>Which ethnic group(s) do you belong to? Tick the space or spaces which apply to you</small>	<input type="radio"/> New Zealand European <input type="radio"/> Maori <input type="radio"/> Samoan <input type="radio"/> Cook Island Maori <input type="radio"/> Tongan <input type="radio"/> Niuean	<input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Other <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-top: 10px;">Please State:</div>	*Smoking Status:
			<div style="border: 1px solid black; padding: 10px;"> Never Smoked <input type="checkbox"/> Current Smoker <input type="checkbox"/> Ex Smoker <input type="checkbox"/> Quit date..... </div> Would you like help to Quit? <input type="checkbox"/> Yes <input type="checkbox"/> No

IWI	Office Use Only:
	ENTERED <input type="checkbox"/> NES <input type="checkbox"/> LOGGED <input type="checkbox"/> FAXED <input type="checkbox"/> SCANNED <input type="checkbox"/> Signed:.....

*My declaration of entitlement and eligibility

<p>*I am entitled to enrol because I am residing permanently in New Zealand. <i>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></p>	<input type="checkbox"/>
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<p>*I am eligible to enrol because:</p>		
a	<p>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)</p>	<input type="checkbox"/>

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 OR 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"/>

<p>*I confirm that, if requested, I can provide proof of my eligibility</p>	<input type="checkbox"/>	<p><i>Evidence sighted (Office use only)</i></p>
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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 Te Kaika Health, I will be included in the enrolled population of WellSouth Primary Health Network; 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, you will be contacted via email and you will have the option to opt out, all responses will be anonymous. The survey provides important information that is used to improve health services.
 I understand that the practice may share my health information between healthcare providers using HealthOne, a secure system for storing electronic patient records and that all information is kept confidential and checks are in place to monitor all access.
 I understand that further information on HealthOne is available from the practice on request.
 I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

*Signatory Details	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
	*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.

<p>Authority Details <i>(where signatory is not the enrolling person)</i></p>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Full Name	Relationship	Contact Phone
Authority Details	Basis of authority (e.g. parent of a child under 16 years of age)		

ConnectMed – Patient Portal Registration Form.

Our patient portal allows you to make appointments, see your clinical notes, results and request repeat scripts.

Please complete this form register for the ConnectMed patient portal.

Each person that uses the portal must have their own unique email address.

Full Name: _____

Date of Birth: _____

Email Address: _____

Cell Phone: _____

Signature: _____

Date: _____

Practice use only

Patient NHI: _____

Staff Member: _____

Date: _____