Nelson Bays Primary Health
Hauora Matua ki Te Tai Aorere

TOI TOI MEDICAL

10 Natalie Street, Nelson 7010
Phone: 03 548 3109 Fax: 03 548 1683 EDI: debsuznl

NHI:

ENROLMENT FORM

Legal Name (as per passport/birth certificate)	Given/First Name	Middle Name(s)	Family Name
Other Name	Name you like to be known by	Other family name e.g. maiden name	
Birth Details	Day /month/Year of birth	Country of birth	
Gender	Male / Female	Gender Diverse (please state)	
Residential Address	House (or RAPID) number and street name	Suburb	Town and Postcode
Postal Address (if different from residential address)	House number and street name or PO box number	Suburb	Town and Postcode
Contact Details	Mobile phone	Home phone	Email address
Employment	Occupation and Employer		Work Phone
Emergency Contact	Name and Relationship		Phone number

Ethnicity (tick all that apply)

11. NZ European / Pakeha ☐	33. Tongan ☐	43. Indian ☐
12. Other European ☐	34. Niuean ☐	44. Other Asian ☐
21. NZ Māori Iwi/Tribe:_____ ☐	35. Tokelauan ☐	51. Middle Eastern ☐
30. Other Pacific Island ☐	36. Fijian ☐	52. Latin American / Hispanic ☐
31. Samoan ☐	41. South East Asian ☐	53. African ☐
32. Cook Island Māori ☐	41. Chinese ☐	61. Other ethnicity ☐

If parents are separated as whose address does the child normally reside?

Mother/Guardian ☐	Father/Guardian ☐	Address:
Legal Access: If a person does not have legal access to your chid please provide a copy of the court order	Name:	Court order attached (please tick) ☐

Do you smoke tobacco? (Please circle the answer that applies to you)
Yes | No, I gave up ..... (please state how long ago) | No, I have never smoked

Do you consent to receive communication from us via text messaging or email? Yes ☐ No ☐

Do you consent to having your basic medical information accessed by other health professionals through Health One? Yes ☐ No ☐

Transfer of Medical 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.*	
	Previous Doctor and/or Practice Name	Signature of consent for transfer of records

Declaration Of Entitlement And Eligibility	
I intend to use this practice as my regular and on-going provider of general practice / GP / health care services.	☐
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, if requested, I can provide proof of my eligibility** below)*	☐

If you are **NOT a New Zealand citizen** please tick which entitlement 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)	☐
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 and 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, if requested, I can provide proof of my eligibility	☐

My agreement to the enrolment process and Toi Toi Medical's Terms of trade

Parent or Caregiver to sign if you are under 16 years

- **I understand** that by enrolling with this practice I will be included in the enrolled population of the Primary Health Organisation (PHO) this practice is contracted to, 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 agree** to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.
- **I have been given Toi Toi Medical's Terms of Trade and I agree to pay for any services provided to me on the day they are provided.**

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.

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)		

OFFICE USE ONLY: Please complete		
Photo ID:	Court order:	
ID:	Alerts updated:	Staff Initial