Nga Kakano GP Services Enrolment Form

50 Jellicoe Street, TE PUKE 3119. Phone: 07 573 0660 Fax: 07 573 4835

NHI Number

(IF KNOWN)

*Indicates Fields that are COMPULSORY

Legal Name *

Family Name First/Given Name

*

Middle Name(s) Type NONE if not applicable

Preferred Name Maiden Name

Date of Birth *

Day Month Year

Place of Birth *

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Country of Birth *

Gender *

Male

Female

Gender diverse (please state below)

Primary Language *

English

Māori

Other (please state below)

Mobile Phone: *

Area Code Phone Number

Home Phone: (if no home phone, please re-enter your cell phone number)

Area Code Phone Number

E-mail

PLEASE NOTE:
You will be able to book appointments online with an email address.

Would you like someone from Ngā Kākano to help you set up a free email address?

Yes

No

Next of Kin / Emergency Contact Name: *

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Relationship: *

Mobile (or other) Phone: *

Do you have a Community Services Card? *

Yes
No

If yes - Day / Month / Year of Expiry

Day Month Year

Card Number (if known)

Do you have a High User Health Card? *

Yes
No

If yes - Day / Month / Year of Expiry

Day Month Year

Card Number (if known)

Ethnicity Details: *

New Zealand European
Māori
Samoan
Cook Island Māori
Tongan Niuean Chinese Indian
Other (such as Dutch, Japanese, Tokelauan - please state below):

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Occupation (applies to 18 years & over ONLY) - choose one option only: *

Yes full-time

Yes part-time

Yes casual

Yes self employed

Not employed

Employer Name: *

Smoking Status (applies to 15 years & over ONLY) - choose one option only: *

Never smoked

Current smoker

Ex-smoker

Would you like support to quit?

Yes

No

Approximate Quit Date (if ex-smoker)

Day Month Year

Consent to Receive Communications via Email - Text - Patient Portal (if available).

Please UNTICK any of the following that you don't consent to: *

Text Message

Email

Facebook Messenger

Patient Portal

Facebook name (if selected)

Are you interested in any other free Ngā Kākano Health Services at this time? (tick as many as you

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like)

- Asthma and respiratory services
- Diabetes services
- Tamariki Ora Well Child Services
- Lactation Breastfeeding Support Services
- Child immunisation programme (outreach – at your home)
- Cervical screening (outreach – at your home)
- Thrive under 5 Play Therapy Programme
- After School Programme: Te Hā o Te Tamaiti (Weds)
- Free Weekly Exercise Programmes
- 12 Week Fitness Challenge for you and your whānau
- Rangatahi/ Youth Early Intervention Service
- Alcohol and drug prevention (10-25 years): Te Whakaoho o Te Mauri
- Addiction Outpatient Day Programme: Aahuru Moowai
- Mental health and addiction counselling
- Kaumatua and Kuia Programme

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.

Transfer of Records - Please choose: *

- Yes - please request transfer of my records
- Not Applicable
- No

Previous Doctor and/or Practice Name: *

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Date Signed *

Day Month Year

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, 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:

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

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 ***Ngā Kākano Family Health Services*** 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

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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 local Ngā Kākano research and 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 'Ngā Kākano Family Health' and undertake to pay any fees applicable for Practice Services & all costs incurred in collection of any debt for myself & my dependents.

Signatory Details *

Self-signing

Authority**

Date Signed *

Day Month Year

**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 Name: *

(where signatory is not the enrolling person)

Relationship: *

Mobile (or other) Phone: *

Basis of authority : *

(e.g. parent of a child under 16 years of age)

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Why is this asked for?
If Ngā Kākano has enough patients working for an employer, we will approach them to offer health checks on-site to try and make our services more accessible for you.

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