A part of

Date:

General Practice Enrol / Re-Enrolment Form

NHI No:

Title		**Surname**		**First Name**	
Other Names (if any)		**Preferred Name**		**Gender**	
Date of Birth		**Country of Birth**		**Day Phone**	
A/Hours Phone		**Mobile Phone**		**Email Address**	
Address: Street		**Address: Suburb**		**Address: City & Postcode**	

I would like my GP - Nirvana Health Group to send me information about my results, recalls and other relevant health related matters electronically via: **Text Messages** - on my mobile no and / or via **Emails** - on my email address	**Yes / No**

Com. Serv. Card No		**Expiry**		**High User Card No**		**Expiry**	

ETHNICITY: Which ethnic group do you belong to? * Mark the space or spaces which apply to you

ETHNICITY	Tick	Other Ethnicity (if applicable)	
New Zealand European			
Māori			
Samoan			
Cook Islands Maori			
Tongan			
Niuean			
Chinese			
Indian			
Other such as DUTCH, JAPANESE, TOKELAUAN. Please state:			

Patient Initials: _____

Enrolment Eligibility:

I intend to use Nirvana Health Group *as my regular and ongoing provider of general practice / GP / First Level primary health care services. I am entitled to enrol because I am residing in New Zealand and meet* ***one of the following eligibility criteria****:* **(I confirm that, if requested, I will provide proof of my eligibility.) -** ***Select 1 criteria only***

a)	I am a New Zealand citizen	**Yes / No**
b)	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	**Yes / No**
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	**Yes / No**
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)	**Yes / No**
e)	I am an interim visa holder who was eligible immediately before my interim visa started	**Yes / No**
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	**Yes / No**
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	**Yes / No**

h)	I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder	**Yes / No**
i)	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)	**Yes / No**
j)	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	**Yes / No**
k)	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university	**Yes / No**
l)	I am under the Commonwealth Scholarship and Fellowship Fund	**Yes / No**

Other Family Members:

Last Name	First Name	Age	Date of Birth	Gender	NHI	Ethnicity	Country of Birth	NZ Resident
				M/F				**Yes/No**
				M/F				**Yes/No**
				M/F				**Yes/No**

My agreement to the enrolment process (*NB* Parent or caregiver to sign if you are ***under*** 16 years)

I choose to enrol with this practice as my regular and ongoing provider of general practice / GP / First Level primary health care services.

- ✓ **I understand** that by enrolling with this practice I will be enrolled with the Primary Health Organisation (PHO) this practice belongs to, and my name address and other identification details will be included on both the Practice and the PHO Enrolment Register.
- ✓ **I understand** that if I visit another 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 with the PHO, and their contact details. I have read and understood the requirements of enrolling with one PHO and choose *Nirvana Health Group's* PHO to be my PHO.
- ✓ **I have read and I agree** with the Health Information Privacy Statement (overleaf).
- ✓ **I agree** to inform the practice of any changes in my eligibility.
- ✓ **I authorize** *Nirvana Health Group* to pass on parts of my health information to the **Ministry Of Health.**
- ✓ **I understand** that relevant health information may be forwarded to other health professionals involved in my care.
- ✓ **I understand** that my health information is accessible by all members of the primary care team and can be accessed at any *Nirvana Health Group* practice so that continuity of care is facilitated through a shared health record.
- ✓ **I understand** that all members of the primary health care team have signed employment contracts containing confidentiality clauses or have signed confidentiality agreements and have completed privacy training so that my personal health information is kept confidential.
- ✓ **I understand** that certain information in my daily clinical records can be made confidential to one GP only if required.
- ✓ **I also understand** that it is my right under the Health Information Privacy Code 1994 to ask to see my personal or Health Information held by the doctor. I can ask for it to be corrected if it is wrong.
- ✓ **I understand** that if I choose to see another doctor I will register at that practice as a Casual Patient, and if I see a GP outside of *Nirvana Health Group* practices frequently, I may be dis-enrolled from the *Nirvana Health Group* practices.
- ✓ **I give permission** for *Nirvana Health Group* to get my medical records from my last doctor. (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).

Name of Previous GP:_____ **Address of Previous GP**:_____

I have enrolled with the *Nirvana Health Group* practice for my ongoing care. Could you please transfer my records along with those of my children listed above to this practice.

Kindly send the records electronically via GP2GP. **GP Name: Dr. Richard Hulme NZMC No: 13934**

East Tamaki Healthcare Health link mailbox address (edi) : estamhcl

Signature_____ **NHI No:** **Date:**

(**Self or 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_____

_____

Detail the basis of authority (e.g. parent of a child under 16): _____

(Casual Patients do NOT need to sign the form)