ENROLMENT FORM

Cambridge Family Health

Fields marked with an * are compulsory	Our Practice is able to receive, and would prefer, electronic GP2GP Notes Transfer **EDI: cambrfam PHONE: (07) 8274234** **EMAIL: admin@cambridgefamilyhealth.co.nz** Dr Christina Benson 45825 Dr Jeremy Baker 25578	*NHI *(Office use only?*

Name

(Title)	*Given Name	* Other Given Name(s))	* Family Name

Birth Details

	* Day / Month / Year of Birth	*Place of Birth	*Country of birth

Gender

☐ *Male ☐ *Female ☐ *Gender diverse (please state)

Residential Address

	*House (or RAPID) Number and Street Name	*Suburb/Rural Location	*Town / City and Postcode

Contact Details

	Mobile Phone	Home Phone	Email Address

Do you consent to the practice sending TEXT messages for the purpose of recalls, surveys & updating your details? ☐ Yes ☐ No

Do you consent to the practice sending EMAILS for the purpose of recalls, surveys & updating your details? ☐ Yes ☐ No

Emergency Contact

Name	Relationship	Mobile (or other) Phone

Transfer of Records I agree to Cambridge Family Health obtaining my records from my previous doctor, which will mean I will be removed from their practice register.

☐ Yes, please request transfer ☐ Not applicable

Signature

Previous Doctor and/or Practice Name and Address

Date

***Ethnicity Details**

Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you

- ☐ New Zealand European
- ☐ Maori
- ☐ Samoan
- ☐ Cook Island Maori
- ☐ Tongan
- ☐ Niuean
- ☐ Chinese
- ☐ Indian
- ☐ Other (such as Dutch, Japanese, Tokelauan). Please state

Iwi:

Hapu:

Community Services Card Number	*Expiry Date*
High User Health Card Number	*Expiry Date*

Smoking status (if over 15)

☐ Never smoked ☐ Ex-smoker - ☐ Greater than 15months ☐ less than 12 months ☐ Current smoker

If you are a current smoker or have recently quit, we would like to help you stop, to improve your health. Would you like help to stop/stay an ex-smoker?

☐ Would you like support to quit? ☐ Yes ☐ No

I agree to be bound by the following conditions of credit:

1. All accounts are payable on the day that the service is provided.
2. An administration fee of $10.00 will be charged if account is not paid on the day.
3. I shall pay or reimburse all costs and/or expenses incurred by Cambridge Family Health in recovering any amount overdue for payment by me.

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 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 can provide proof of my eligibility	☐	Evidence sighted (*Office use only*)
My work/student/visitor/other visa is valid for a period of	Year(s):	Expiry Date:

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 the Cambridge Family Health I will be included in the enrolled population of National Hauora Coalition 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 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 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.

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)		