



56 Rawhiti Avenue, Matamata
 Ph (07) 8819102/881 9104 Fax
 (07) 881 9103
 Family Dental Centre (Matamata)



ENROLMENT FORM

Legal Name*		(Title)	Given Name	Other Given Name(s)	Family	
Other Name(s) (eg.maiden name) Please tick the name you prefer to be known as			NHI (office use only)		I.D.:	Photo ID sighted <input type="checkbox"/> Address Verified <input type="checkbox"/>
Birth Details*			Day/Month/Year of Birth*	Place of Birth*	Country of Birth*	
Gender*			<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)	
Employer		Address			Phone	
Usual Residential Address*		House# and Road/Street name			Suburb/Rural Location	
Postal Address (if different from above)		House # & Street Name or PO Box #			Suburb/Rural Location	
Contact Details		Mobile Phone	Home Phone	I agree to receiving TXT messages: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Emergency Contact/NOK		Name		Relationship		Mobile (or other) Phone
Previous Residential Address*		Suburb/Rural Location			Town / City & Postcode	
Community Services Card		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day/Month/ Year of Expiry	Card #	
High User Health Card		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day/Month/ Year of Expiry	Card #	
Ethnicity Details		Smoking Status			Family Dental Enrolment	
Which ethnic group do you belong to? (Tick box/es that apply to you)		Smoker <input type="checkbox"/> Never Smoked <input type="checkbox"/> Ex-Smoker <input type="checkbox"/> Years since quit			Yes I Wish to enrol (circle one)	
		Brief Advice given: Yes/No Appointment with Nurse: Yes/No			No thanks	
Patient Survey		From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.				
New Zealand European		Patient Survey Contact Details: <input type="checkbox"/> YES or <input type="checkbox"/> NO I do not wish to participate in the Patient Survey				
Maori						
Samoan						
Cook Island Maori						
Tongan						
Niuean		<input type="checkbox"/> Yes, please request transfer of my record		<input type="checkbox"/> No transfer		<input type="checkbox"/> Not applicable
Chinese		Previous Doctor and/or Practice Name:			Address / Location	
Indian						
Other (such as Dutch, Japanese, Tokelauan). Please state:						
		EDI: matamedc		Doctor:		NZMC

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, if requested, I can provide proof of my eligibility

Evidence sighted (Office use only)

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 **Matamata Medical Centre**. I will be included in the enrolled population of the Hauraki Primary Health Organisation (HPO) 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.

Signatory Details	Signature	Day / Month / Year	<input type="checkbox"/> Self Signing	<input type="checkbox"/> Authority
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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	Full Name	Relationship	Contact Phone
(where signatory is not the enrolling person)	Basis of authority (e.g. parent of a child under 16 years of age)		

Version 1
Date: 28 September 2016

Approved by HPHO Management Team
Review Date: 28 September 2018

MASTERCOPY
HPHO Enrolment Form Template