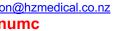
healthzonemedical	ENR A: 17 Antares P: 09 477 209 Email: reception@ EDI : milenu
Provider: GP2GP:	

ENROLMENT FORM

17 Antares Place, Rosedale, Auckland, 0632 09 477 2090 nail: reception@hzmedical.co.nz





- □ Dr Andre George # 60723
- Dr Fuma Naito # 84407
- Dr Josh Lee # 81812
- Dr Linda Munch # 94902

(Office Use Only) Eligibility & Entitlement Valid passport /Visa/ID Form signed & dated Req. for notes Scanned to file

NHI:

Legal Name *	(Title)	Given Name		Middle Name(s)	Middle Name(s)		Family Name		
Other Nam	, ,								
(eg. maiden n	•••								
/preferred na									
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		Day/Month	/Year of E	Birth	Place of Birth		Country of Birth		
<mark>Gender *</mark>									
		Male	Female	e Ger	der diverse (please state)				
Optional		Marital Stat	us				Occupation		
Usual Resid	dential								
Address *		House (or R	APID) Nu	mber and	l Street Name	Su	Suburb/Rural Location Town/City and Postco		
Postal Add (if different from						6			
*Contact D	otaile	House Num	ber and S	treet Na	me or PO Box Number	Su	burb/Rural Delivery	Town/City and Postcode	
	etalis	Mobile Pho	ne		Home Phone	Email Address			
*Emergenc	<mark>y</mark>								
Contact/N	<mark>)</mark>	Name				Re	lationship	Mobile (or other) Phone	
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O Other		Other (such as Dutch,							
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Unalth	Zone Modi	L ical Enrolment	Form /	IFS comp					
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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)	
с	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)	
е	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

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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 HealthZone Medical I will be included in the enrolled population of Comprehensive Care 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					
(Full Name	Relationship	Contact Phone		
(where signatory is not the enrolling person)					
Authority Details	Basis of authority (e.g. parent of a child under 16 years of age)				

*

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