



Fields shaded in grey are compulsory

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**EDI: dr39luck Dr Frederick Goh NZMC 65903**

NHI (Office use only)

Name	(Title)	Given Name		Other Given Name(s)	Family Name		
		Preferred Name		Other Name(s) (eg. maiden name)			
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)	Occupation

Usual Residential Address	House Number and Street Name	Suburb/Rural Location	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

Contact Details (at least 1)	Mobile Phone	Home Phone	Email Address
Emergency Contact	Name	Relationship	Mobile (or other) Phone

Previous GP	Practice Name & Address
Community Services Card	Card Number Day / Month / Year of Expiry
Smoking history?	<input type="checkbox"/> Currently smoke <input type="checkbox"/> Recently quit <input type="checkbox"/> Ex-smoker (>1 year) <input type="checkbox"/> Never smoked
Current Smoker?	Would you like some help to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Ethnicity Details</b> Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	<input type="radio"/> New Zealand European	<b>Signatory Details</b> <input type="checkbox"/> Self-Signing <input type="checkbox"/> Authority	<b>Signature</b> _____	<b>Day / Month / Year</b> _____		
	<input type="radio"/> Maori			<i>Where the signatory is not the enrolling person. An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.</i>		
	<input type="radio"/> Samoan	<b>Authority Details</b> _____		<b>Full Name</b> _____		
	<input type="radio"/> Cook Island Maori	<b>Basis of authority (e.g. parent of a child under 16 years of age) / Relationship</b> _____				
	<input type="radio"/> Tongan	<b>Contact Phone</b> _____				

# ENROLMENT FORM - Declaration of Entitlement and Eligibility

**I am entitled to enrol because I am residing permanently in New Zealand.**

*Residing permanently in NZ means you intend to stay in New Zealand for at least 183 days / 6months in the next 12 months*

**I am eligible to enrol** because:

a	I am a New Zealand citizen <i>(If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below)</i>	<input type="checkbox"/>
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If you are **not** a New Zealand citizen please tick ONE of the eligibility criteria (b–j) below which applies to you:

b	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	<input type="checkbox"/>
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	<input type="checkbox"/>
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)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
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	<input type="checkbox"/>
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 <b>OR</b> in the control of the Chief Executive of the Ministry of Social Development	<input type="checkbox"/>
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)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
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	<input type="checkbox"/>

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 DOCTORS ON LUCKENS, I will be included in the enrolled population of THE NATIONAL HAUORA COALITION, 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.

In regards to the transfer of old records, the Practice will only obtain my records from my previous Doctor for the best continuity of care **ONLY** if I agree and I understand that **if I agree**, I will be removed from my previous Doctor's practice register.

**Yes, I agree to transfer my records**

**No, I do not wish to transfer my records**

<b>Signatory Details</b>	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.*

<b>Authority Details</b> <small>(where the signatory is not the enrolling person)</small>	Full Name	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age)		