National Hauora Coalition	REGISTRATION FORM	Doctors on Luckens

Fields shaded in grey are compulsory	***39 Luckens Road, West Harbour, Auckland, New Zealand 0618*** ***Ph:*** *09 416 4538,* ***Fax:*** *09 416 7518,* ***EDI:*** *dr39luck* ***Email:*** *reception@doctorsonluckens.co.nz* ***Website:*** *ww.doctorsonluckens.co.nz*	NHI *(Office use only)*

Name	*(Title)*	*Given Name*	*Other Given Name(s))*	*Family Name*
Preferred Name			**Other Name(s)** e.g. maiden name	
Birth Details		*Day / Month / Year of Birth*	*Place of Birth*	*Country of birth*
Gender	☐ *Male*	☐ *Female*	☐ *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?	☐ ***Currently smoke***	☐ ***Recently quit***	☐ ***Ex-smoker (>1 year)***	☐ ***Never smoked***
Current Smoker?	***Would you like some help to quit?***	☐ ***Yes***	☐ ***No***	

Ethnicity Details Which ethnic group(s) do you belong to? ***Tick the space or spaces which apply to you***	◯ New Zealand European ◯ Maori ◯ European ◯ Samoan ◯ Cook Island Maori ◯ Tongan ◯ Niuean ◯ Pacific Islander (if not above) ◯ Chinese ◯ Indian ◯ Other; Please state:	**Signatory Details**	***Signature:***	***Day / Month / Year***
		☐ ***Self-Signing*** **OR** ☐ ***Authority***		
		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.		
		Authority Details	***Full Name:***	
		Basis of authority (e.g. parent of a child under 16 years of age) / Relationship: ***Contact Phone:***		

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** *(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 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)	☐
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 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**

Signatory Details	*Signature:*	*Day*	*Month*	*Year*	☐ *Self-Signing* **OR** ☐ *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 the 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)		