MOA MEDICAL
12 Brown St Inglewood 4330
***Ph:* 06 756 7777**
***Email:* moaadmin@phcl.health.nz**

PATIENT ENROLMENT FORM

Each Person 16 years or over to complete and sign own form
Each enrolled patient must have their own enrolment form

***Must be completed** NHI: (Office Use Only)* Chart No.:

1. Personal Details:

Title: **Family Name:** **First Name/s:***

Preferred Name: **Other name/s known by and/or Maiden name:**

Date of Birth:* **Gender:*** **Gender Self Identified:** **Sex at birth:**

M/F **M/F**

Account holder: Please Tick ✓

Y **N** ✓

Town/City of birth:

2. Contact Details:

Physical Address:*

Unit/House No: **Street:** **Suburb:**

Town/City: **Postcode:**

Home Phone: **Work Phone:** **Mobile Phone:**

Email Address:

Postal Address: (If different from Physical Address)

PO Box/Unit/ House No: **Street:** **Suburb/Rural Delivery:**

Town/City: **Postcode:**

Preferred Contact Methods: Please Tick ✓

Secure Email **Text** **Landline** **Cell Phone** **Post**

Consent to use text messaging:
Yes / No Please Circle One

Contact Methods:

Transfer of Records		
In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register.		
Yes, please request transfer of my records	No transfer	Not applicable
Previous Doctor / Practice Name	Address / Location	
***EDI:** dianejns*		

3. Ethnicity*:

WHICH ETHNIC GROUP DO YOU BELONG TO? (YOU MAY SELECT UP TO THREE ETHNICITIES):

Māori Iwi _____	21		Tokelauan	35		Not Stated	99	
NZ European/Pakeha	11		African	53		Declined	98	
Samoan	31		Other Pacific Peoples	37		Latin American/Hispanic	52	
Cook Island Maori	32		Middle Eastern	51		Fijian	36	
Tongan	33		South East Asian	41		Other European	12	
Niuean	34		Asian nfd	40		Other Asian	44	
Chinese	42		European nfd	10		Pacific Peoples nfd	30	
Indian	43		Don't Know	94				
Other Ethnicity (please state)	61		Refuse to Answer	95				

4. Residential Status:A PASSPORT OR BIRTH CERTIFICATE MUST BE PROVIDED ON ENROLMENT

Country of Birth:*
If New Zealand is your country of birth, go to Q5

If You are not born in NZ,

Are you a NZ resident? Yes ☐ No ☐

Are you a refugee: Yes ☐ No ☐

Are you on working Visa? Yes ☐ No ☐

Visa/Permit Sighted: (Office Use Only) Yes ☐ No ☐

5. Next of kin/Emergency Contact Details:

Title: **Family Name:**

First Name/s: **Relationship:**

Physical Address:

Unit/House No: **Street:** **Suburb:**

Town/City: **Postal Code:**

Day Phone: **Mobile Phone:**

6. Community Health Details:

Community Services Card No: Expiry Date:

Sighted:(Office Use Only) Yes ☐ No ✓

High User Health Card No: Expiry Date:

Sighted:(Office Use Only) Yes ☐ No ✓

7. Employer:

Name:

Address:

Town/City: Phone:

Occupation

8. Smoking Status:

Smoking status is an important factor influencing health.Please tick the space that applies for those aged 15 and over.

☐ Never Smoked ☐ In the past smoked daily for more than a year but no longer smoke ☐ Currently a Smoker

Approximate Quit Date _____

Smoking is hugely negative on your good health. In most cases, you will experience the benefits of quitting immediately.

If you currently smoke, would you like some help to quit?

☐ Yes ☐ No

Signed Authority:

I intend to use Moa Medical as my regular and ongoing provider of general practice / GP / First Level primary health care services.

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, then proceed to I confirm that, if requested, I can provide proof of my eligibility below)	No
If you are <u>not</u> a New Zealand citizen following eligibility criteria applies to you (b–k) below: b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010	No
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	No
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)	No
e) I am an interim visa holder who was eligible immediately before my interim visa started	No
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	No
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	No
h) I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder (If yes, encircle yes)	Yes / No
i) 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)	No
j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	No
k) I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund.	No

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 / First Level primary health care services.
I understand that by enrolling with **Moa Medical** I will be included in the enrolled population that the Primary Health Organisation (PHO) this practice belongs to , and my name address and other identification details will be included on 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 2020.
I understand that the Practice participates in the 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 or opt out of the survey by informing the Practice. The survey provides important information that is used to improve the health services.
I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

	#Error Day Month Year
SIGNATURE	**DATE**

OR signed by AUTHORITY2

Name of Authority:	Phone Number:	Relationship:
Address:	Signature of Authority:	**#Error** Day Month Year

1 The definition of residing in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months.
2 An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.