



1. Last name: _____

2. First names: _____

3. Date of birth: ____ / ____ / ____
day month year

4. Sex: [] Male [] Female [] Other

5. Place and Country of birth: _____

6. Which ethnic group(s) do you belong to? Mark the space or spaces which apply to you.

[] New Zealand European

[] Maori

[] Samoan

[] Cook Island Maori

[] Tongan

[] Niuean

[] Chinese

[] Indian

[] Other such as Dutch, Japanese, Tokelauan. Please state: _____

7. Physical address: Number and street: _____

Suburb: _____

City: _____ Post code: _____

8. Home phone: _____

Work phone: _____

Cell phone: _____

9. Are you happy for us to send you text messages? [] Yes [] No

10. Email address: _____

11. Next of kin / Emergency contact: _____

Relationship to you: _____ Contact number: _____

12. Name of previous doctor or surgery: _____

Address of previous doctor: _____

13. Do you smoke? [] Yes [] No

14. If yes, do you want help to quit? [] Yes [] No

15. Do you have a Community Services Card? [] Yes [] No

CSC no. _____ Expiry date: _____

Winz client no. _____

16. Do you have a High User Health Card? [] Yes [] No HUHC no. _____

17. Would you like to set up an automatic payment? [] Yes [] No

18. Do you wish to take part in the New Zealand patient experience survey? [] Yes [] No

Office use only:

Fax:

Phone:

NHI:

19. Enrolment with Health Hawke's Bay and the Practice

I intend to use Totara Health as my regular and ongoing provider of general practice for primary health care services.

I am eligible to enrol because **I live permanently in New Zealand and meet one** of the following criteria:

- a) I am a New Zealand citizen ☐
- 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 old and in the care and control of a parent/legal guardian/adopting parent who meets one criterion in clauses a-f above ☐
- h) I am a New Zealand Aid Programme student studying in New Zealand 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 New Zealand and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund. ☐

20. I confirm that, if requested, I can provide proof of my eligibility. ☐

21. My agreement to the enrolment process

- a. **I choose to enrol with Totara Health as my regular and ongoing provider of general practice for primary health care services.**
- b. **I understand** that by enrolling with Totara Health I will be enrolled with Health Hawke's Bay which this practice belongs to, and my name, address and other identification details will be included in the Totara Health, Health Hawke's Bay and National Enrolment Service Registers.
- c. **I understand** that if I visit another provider where I am not enrolled I may be charged a higher fee.
- d. **I have been given information** about the benefits and implications of enrolment with Health Hawke's Bay and have been provided their contact details.
- e. **I have read and I agree** with the Health Information Privacy Statement. The information I have provided on the Enrolment Form will be used to determine my eligibility to receive publically-funded services. Information may be compared with other government agencies but only when permitted under the Privacy Act.
- f. **I agree** to inform the practice of any changes in my eligibility.
- g. **I agree** to pay for all consultations at the time of my appointment.
- h. **I agree** to Totara Health obtaining my records from my previous Doctor.

To be signed by a parent or guardian if you are under 16 years of age

Name: _____
Please print

Signature: _____
Today's date ___/___/___
Day Month Year

OR Signed by AUTHORITY (has the legal right to sign for another person if for some reason they are unable to consent on their own behalf)

Full name of Authority: _____ **Phone:** _____

Relationship: _____

Address: _____

Signature of Authority: _____
Today's date ___/___/___
Day Month Year

Healthlink address: wiggins

Totara Health Flaxmere Corner of Chatham Road and Caernarvon Drive Flaxmere 4120 Ph 873 9024 - Fax 873 9021

Totara Health Hastings 403 Nelson Street North, Hastings 4122 Phone 873 0101 - Fax 873 0103

P O Box 1079 Hastings 4156

ID sighted: [] Passport / Visa [] Birth Certificate [] Other _____

Form complete? ☐

Staff initials: ☐