



**Hobsonville
Family Doctors**
Comprehensive Medical + Healthcare

ENROLMENT FORM

124 Hobsonville Road,
Hobsonville, Auckland 0618
PO Box: 317075, Hobsonville 0664
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EDI: luckenmc admin@hfd.co.nz
www.hobsonvillefamilydoctors.co.nz



**Dr Paul Nicholls (14913), Dr Jann Singer (11307), Dr Julyan Lawry (19542),
Dr Joanne Shooter (19561), Dr Torrance Merkle (64593) & Dr Halima Nati (66583)**

NHI

Legal Name *	(Title)	Given Name	Middle Name(s)	Family Name
Other Name(s) (eg. maiden name /preferred 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)	
Optional	Marital status			Occupation

Usual Residential Address *	House (or RAPID) 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	Mobile Phone	Home Phone	Email Address
*Emergency Contact /NOK	Name	Relationship	Mobile (or other) Phone

Community Services Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number
High User Health Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Day / Month / Year of Expiry	Card Number

Transfer of Records	<i>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, as I am only able to be enrolled at 1 practice at a time in NZ</i>		
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor and/or Practice Name		Address / Location

*Ethnicity Details Which ethnic group(s) do you belong to? Tick the space or spaces which apply to you	<input type="radio"/> New Zealand European	Primary Language Spoken:
	<input type="radio"/> Maori	
<input type="radio"/> Samoan	<input type="radio"/> Cook Island Maori	IWI
<input type="radio"/> Tongan	<input type="radio"/> Niuean	* Smoking status (if over 15) Never smoked <input type="checkbox"/> Ex-smoker <input type="checkbox"/>
<input type="radio"/> Chinese	<input type="radio"/> Indian	Greater than 15months <input type="checkbox"/> less than 12 months <input type="checkbox"/> Current smoker <input type="checkbox"/>
<input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state		Would you like support to quit? Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/> I authorise Hobsonville Family Doctors to contact me via text message
<input type="checkbox"/>		<input type="checkbox"/> I authorise Hobsonville Family Doctors to contact me via email (non-secure)

* My declaration of entitlement and eligibility *

I am entitled to enrol because I am residing permanently in New Zealand. <i>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>	<input type="checkbox"/>
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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 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)	<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 OR 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	<input type="checkbox"/>	Evidence sighted <i>(Office use only)</i>
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<h2 style="margin: 0;">My agreement to the enrolment process</h2> <p style="margin: 0;">NB. Parent or Caregiver to sign if you are under 16 years</p>

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 Hobsonville Family Doctors 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	<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.

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