ENROLMENT FORM

Epic Health Medical Practice www.epichealth.nz		Contact Details: admin@epichealth.nz 67 Willow Street, Tauranga 3110. Tel: 0800 374 254 0800 EPIC KIWI Fax: 09 355 0508	
Provider: Dr Emma Stanley	**NZMC: 63562**	**EDI: epicheal**	**NHI**

*** Indicates Fields that are COMPULSORY** **Fields above for Office Use ONLY**

Legal Name	Title	Surname/Family Name*	First/Given Name*	
	Middle Name(s)*	Preferred Name	Maiden Name	
Birth Details	Day / Month / Year of Birth*	Place of Birth*	Country of Birth*	
Gender	◯ Male ◉ Female ◯ Gender diverse (please state)*		Primary Language	

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	

Next Of Kin / Emergency Contact	Name	Relationship	Mobile (or other) Phone
	Address		

Community Services Card	◯ Yes	◉ No	Day / Month / Year of Expiry	Card Number (if known)
High User Health Card	◉ Yes	◯ No	Day / Month / Year of Expiry	Card Number (if known)

Ethnicity Details

Which ethnic group(s) do you belong to?

* ***Select 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:

IWI	
Occupation	
Employer & Address	

Smoking Status (applies to 15 years & over ONLY)

Never smoked ◯ Current smoker ◯ Ex-smoker ◯

Approximate Quit Date

Smoking is bad for your health. Would you like support to quit? Yes ◉ No ◯

Tick the box if you DO NOT want to receive communications by:

☐ Text Message ☐ Patient Portal (Secure)

☐ Email (non-secure)

Transfer of Records Authority

In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor.
I understand I will be removed from their practice register, as I am only able to be enrolled at 1 practice at a time in NZ.

◉ Yes - please request transfer of my records
◯ Not Applicable ◯ No

Previous Doctor and/or Practice Name

Signature Day / Month / Year

Practice Address / Location

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My declaration of entitlement and eligibility

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, 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 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)	◯
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 I have provided 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 **Epic Health Medical Practice** I will be included in the enrolled population of **Western Bay of Plenty PHO** 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 or informed 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 shared 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.

I agree to the Terms and Conditions of Trade of Epic Health Medical Practice and undertake to pay any fees applicable for Practice Services & all costs incurred in collection of any debt for myself & my dependents.

Signatory Details	Signature*	Day / Month / Year*	◉ Self-Signing	◯ 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 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)		