



## ENROLMENT FORM

**RURAL CANTERBURY**  
Primary Health Organisation  
Te Roopu Hauora Matua O Waitaha Taiwhenua

42 Charles Street  
Kaiapoi  
7630

Tel: 03 327 7474  
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Email: [reception@kfd.co.nz](mailto:reception@kfd.co.nz)

EDI: kfdactor  
Dr Graham Wesley

NZMC  
22831

NHI (Office use only)

<b>Legal Name</b>	(Title)	Given Name	Middle Names(s)	Family Name
<b>Preferred Name</b> (eg. Nickname)			<b>Other Name (s)</b> (eg. Maiden name)	
<b>Birth Details</b>		Day / Month / Year of Birth	Place of Birth	Country of birth
<b>Gender</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Gender diverse (please state)	Occupation

<b>Usual Residential Address</b>	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
<b>Postal Address</b> (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

<b>Contact Details</b>	Mobile Phone	Home Phone	Email Address
<b>Emergency Contact</b>	Name	Relationship	Mobile (or other) Phone

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

<b>Transfer of Records</b>	<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.</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

<b>Ethnicity Details</b>  Which ethnic group(s) do you belong to?  <i>Tick the space or spaces which apply to you</i>	<div><input checked="" type="checkbox"/> New Zealand European</div> <div><input checked="" type="checkbox"/> Maori</div> <div><input checked="" type="checkbox"/> Samoan</div> <div><input checked="" type="checkbox"/> Cook Island Maori</div> <div><input checked="" type="checkbox"/> Tongan</div> <div><input checked="" type="checkbox"/> Niuean</div> <div><input checked="" type="checkbox"/> Chinese</div> <div><input checked="" type="checkbox"/> Indian</div> <div><input checked="" type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan). Please state</div> <div></div>	<table><tr><td><b>Smoking</b></td><td><i>Never smoked</i></td><td><input type="checkbox"/></td><td><i>Ex smoker &lt;12 months</i></td><td><input type="checkbox"/></td></tr><tr><td><b>Status</b></td><td><i>Current smoker</i></td><td><input type="checkbox"/></td><td><i>Ex smoker &gt;12 months</i></td><td><input type="checkbox"/></td></tr><tr><td colspan="5"><i>Are you happy for your Dr to have access to your medical records from other health providers (Health One)?</i></td></tr><tr><td colspan="5">Yes <input type="checkbox"/> No <input type="checkbox"/></td></tr><tr><td colspan="5"><i>Are you happy to receive text messages?</i></td></tr><tr><td colspan="5">Yes <input type="checkbox"/> No <input type="checkbox"/></td></tr></table>	<b>Smoking</b>	<i>Never smoked</i>	<input type="checkbox"/>	<i>Ex smoker &lt;12 months</i>	<input type="checkbox"/>	<b>Status</b>	<i>Current smoker</i>	<input type="checkbox"/>	<i>Ex smoker &gt;12 months</i>	<input type="checkbox"/>	<i>Are you happy for your Dr to have access to your medical records from other health providers (Health One)?</i>					Yes <input type="checkbox"/> No <input type="checkbox"/>					<i>Are you happy to receive text messages?</i>					Yes <input type="checkbox"/> No <input type="checkbox"/>				
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**My declaration of entitlement and eligibility**

<b>I am entitled to enrol</b> 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	<b>I am a New Zealand citizen</b> <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 <b>OR</b> 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"/>

<b>I confirm that, if requested, I can provide proof of my eligibility</b>	Yes <input type="checkbox"/>	Evidence sighted <i>(Office use only)</i>	Passport <input type="checkbox"/>	Birth Certificate <input type="checkbox"/>
			Visa <input type="checkbox"/>	CSC/Gold card <input type="checkbox"/>

## 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 **Kaiapoi Family Doctors** I will be included in the enrolled population of **Rural Canterbury 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** 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 agree** to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

<b>Signatory Details</b>			<input type="checkbox"/>	<input type="checkbox"/>
	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.**

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