Practice Enrolment Form

LEVIN FAMILY HEALTH
Focusing on Your Health and Wellbeing

Practice Name:	Levin Family Health	Phone Number:	06 777 9200		
Address:	130A Speldhurst Parade, Levin 5510	EDI Number:	lfh23adl	NZMC:	35851
GP Provider:	Andre de Lange	Email:	enrolment@levinfamilyhealth.co.nz		

Please completed ALL areas in BLUE

Legal Name	Title:	Surname:	First Name:	
			Middle Name:	

NHI:			Date of Birth:	
Gender:	Male	Female	Gender Diverse *(please state)*	Place of Birth:
Occupation:			Employer Name:	

Community Services Card	
Yes	No
Card Number:	
Card Expiry Date:	

High User Health Card	
Yes	No
Card Number:	
Card Expiry Date:	

Residential Address	Street Number:	Street Name:		
	Suburb:	City:	Postcode:	
Postal Address *(if different from above)*				
Home Phone:		Work:	Mobile:	
Email:		NOK:		
Do you agree to receive emails?	Yes / No	Relationship:		
		Phone Number:		

Do you agree to receive text messages?	Yes	No	**Do You Smoke?**	Smoker	Ex-Smoker	Never

Which Ethnic Group do you belong to? *(Tick the space or spaces that apply to you)*	
NZ European	
Māori	
Samoan	
Cook Island Māori	
Tongan	
Chinese	
Niuean	
Indian	
Other: *(Please state)*	

Transfer of Records

In order to get the best care possible, I agree to this Practice obtaining my records from my previous Practitioner. I also understand that I will be removed from their practice register.

I accept that my hard file medical records may not be retained with my new Practitioner.

Yes	No	Not Applicable

Previous Practitioners Name:

Address:

Phone:

Signature: *(Agreement to transfer records)* | Date:

Iwi	If Māori decent, please enter up to 3 Iwi or home area of affiliation	Iwi 1:	Iwi 2:	Iwi 3:

	I wish to join ManageMyHealth online patient portal so that I have access to my results, medication requests and online appointment bookings *(please tick the box to the left)*

Patient Signature:	Please provide Photo ID	
	Personal Email Address	

My Declaration of Entitlement

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 a 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 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 resident 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 a least 2 consecutive years.	
D	I have a work visa/permit and can show that I am able to be in New Zealand for a 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 or people trafficking	
G	I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets on criteria 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 of child under 18 years old)*	
I	I am participating in the Ministry of Education Foreign Language Teaching Assistance Scheme.	
J	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand University un the Commonwealth Scholarship and Fellowship fund.	

I confirm that, if requested, I can provide proof of my eligibility.	
We will retain a copy for eligibility purposes only — Evidence sighted *(office use only)*	

My agreement to the enrolment process

NB: Parent of caregiver to sign if you are under 16years

→	**I intend to use this practice** as my regular and ongoing provider of general practice/GP/NP health care services.
→	**I understand** that by enrolling with this practice I will be included in the enrolled population of THINK Hauora PHO and my name and address and other identification details will be included on the Practice, PHO and National Enrolment Service Register
→	**I understand** that id 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. If 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 participation in a national survey about people's health care experiences 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:	Date:	Self-Signing	Authority

An **Authority** has the legal right to sign for another person if for some reason they are unable to consent on the 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)