



Cambridge Family Health
2 Oliver Street
Cambridge

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Dr Prabani Wood
Dr Kerry Taylor

Legal Name*	(Title)	Given Name	Other Given Name(s)	Family Name	
Other Name(s) (eg maiden name) Please tick the name you prefer to be known as			NHI (office Use only)		I.D.: Photo I.D. sighted <input type="checkbox"/> Address Verified <input type="checkbox"/>
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)	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	I agree to receiving Txt messages Yes <input type="checkbox"/> No <input type="checkbox"/> 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	
Ethnicity Details		Smoking and Alcohol Status			
Which ethnic group do you belong to? (Tick box/es that apply to you)		Do you drink alcohol?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/> 1-5 units per week <input type="checkbox"/> 6-10 units per week <input type="checkbox"/> 11-15 units per week <input type="checkbox"/> 15 or more units per week
<input type="radio"/> New Zealand European <input type="radio"/> Maori <input type="radio"/> Samoan <input type="radio"/> Cook Island Maori <input type="radio"/> Tongan <input type="radio"/> Niuean <input type="radio"/> Chinese <input type="radio"/> Indian <input type="radio"/> Other (such as Dutch, Japanese, Tokelauan). Please state:		Smoking Status:	Smoker <input type="checkbox"/>	Never Smoked <input type="checkbox"/>	Ex-Smoker <input type="checkbox"/> No. years since quit
		We encourage you to be smoke-free. If you would like some help to become smoke-free, please let us know.			
		Patient Survey From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.			
		Patient Survey Contact Details: As provided above <input type="checkbox"/> (or)			
		Alternative Email Address			
		Alternative Mobile Phone			
		<input type="checkbox"/> I do not wish to participate in the Patient Survey			
		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.			
Transfer of Records		<input type="checkbox"/> Yes, please request transfer of my records – please complete the attached form		<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
		Previous Doctor and/or Practice Name		Address / Location	

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

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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)

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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

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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 the Cambridge Family Health, I will be included in the enrolled population of the Hauraki Primary Health Organisation (HPHO) 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.

Signatory Details			<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.

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)		