RATANUI MEDICAL
(Total Healthcare PHO)

ENROLMENT FORM

(Circle) **Enrolment / Update / Casual**

PHO Release Authorisation

77 Lincoln Road Henderson Auckland 0610
PO Box 104242 Lincoln North Auckland 0654
Ph (09) 837 0740 Fax (09) 837 0745
Healthlink: ratanuim
www.ratanuimedical.co.nz

PACK NO

DOCTOR (Office Use only)	**NZMC** (Office Use only)	**NHI**

Legal Name Title	**Surname** (Family Name)	**First Name**	**Other Name** (Middle Name)

Other Names (Maiden Name, etc)	**Preferred Name**	**DOB**
Gender **Male** ☐ **Female** ☐ **Gender Diverse** ☐ Please State	**Occupation**	**Country of Birth**
Residential Address Auckland	**Postal Address** (if different)	**Place of Birth**
		Marital Status

Contact Details		
	Phone Hm	
	Phone Wk	
	Mobile	
	Email	

Community Services/Gold Card	Yes ☐ No ☐
Client No	
Card No	
Expiry Date	

I authorise Ratanui doctors and staff to send me information about my results, recalls and other relevant health related matters electronically via Text Messages and/or Emails. Yes ☐ No ☐

High User Health Card	Yes ☐ No ☐
Card No.	
Expiry Date	

Next of Kin **Emergency Contact**	
	Name
	Address
	Phone
	Relationship

TOBACCO
1371 Never Smoked ☐
137S Ex Smoker ☐ Year:
137R Current Smoker ☐ Quantity:
Quitting smoking is the single best thing for your health.
Would you like support to quit? Yes ☐ No ☐

ALCOHOL No ☐ Yes ☐ Quantity:

Which Ethnic group do you belong to? Mark the space or spaces which apply to you		✔
11	New Zealand European	
21	Māori Iwi:	
31	Samoan	
32	Cook Island Māori	
33	Tongan	
34	Niuean	
42	Chinese	
43	Indian	
	Other (ie Dutch, Japanese, Tokelauan) Please state:	

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 may use to improve health Services. Participation is voluntary and anonymous.

Patient Survey Contact Details. As provided above ☐ Or

Alternative Mobile Phone Number

Alternative Email Address

☐ I do not wish to participate in the patient survey

Patient Initial

TRANSFER OF RECORDS TO RATANUI MEDICAL PRIMARY HEALTH ORGANISATION (PHO) Release Authority

PO Box 104 242 Lincoln North Auckand 0654
Healthlink: ratanuim **Fax (09) 837 0745**

I agree and authorise:

MOH Sector Services to release my PHO registration details to Ratanui Medical.

In order to get the best care possible, I agree to Ratanui Medical to obtain my clinical records and health information from my previous doctor. I also understand that I will be removed from the the previous practice register.

Previous Doctor

Medical Centre

Phone

Fax

Enrolment in the practice/primary health organisation

I wish to enrol with Ratanui Medical as my regular and ongoing provider of general practice / First Level primary healthcare services.

PTO

My declaration of entitlement and eligibility for Enrolment

***Please provide ID documentation ie Passport/Birth Certificate, Permits/Visa for proof of Eligibility**.*

(✔ One that applies)

I am entitled to enrol because I am residing in New Zealand Permanently and meet one of the following eligibility criteria *The definition of residing permanently in New Zealand is that you intend to be resident in New Zealand for at least 183 days (6 mths) in the next 12 mnths*	✔

For New Zealand Citizens – I am eligible to enrol because:

a	I am a New Zealand citizen	

If you are NOT a New Zealand citizen - Please tick which entitlement criteria applies to you:

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 two consecutive years	
d	I have a work visa/permit and can show that I am able to be in New Zealand for at least two 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	
h	I am a New Zealand Aid Programme student studying in New Zealand 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 New Zealand and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund	

My agreement to the enrolment process *(Parent or caregiver to sign, if you are under 16 years).*

- I choose to enrol with Ratanui Medical as my regular and ongoing provider of general practice/first level primary health care services and accept that I can only enrol with one practice as determined by the Ministry of Health (MOH). By enrolling with this practice I will be enrolled with the primary health organisation this practice belongs to,Total Healthcare Primary Health Organisation. I have read and understood the requirements of enrolling with one PHO and that my name, address and other identification details will be included on both the practice and the PHO Enrolment Register.
- I understand that if I choose to visit another doctor, I will register at that practice as a Casual patient and may be charged a higher fee. If I visit another practice frequently, I may be disenrolled. I acknowledge that I can change my enrolment from any medical practice at any time.
- For funding and Health Planning purposes, my enrolment contact information will be collated by the PHO, the Waitemata DHB and the MOH. Non personally identifiable clinical information will be aggregated and forwarded as required by the MOH for Health planning and funding. I understand that relevant health information may be forwarded to other health professionals involved in my care.
- To enable Government funding for your medical services we are required to have each person identified by their National Health Index Number (NHI). To confirm your NHI number we contact the Health Funding Authority with your contact details.
- I understand that is it my right under the Health Information Privacy Code 1994 to ask to see my personal or Health Information held by the doctor. I can ask for it to be corrected if it is wrong.
- This practice is entitled to charge a fee for the health services it provides and I agree to pay such costs according to the policy of the practice, including any additional costs associated with the collection of overdue or unpaid accounts.
- I confirm that I reside in New Zealand and meet the criteria and eligibility to enrol for subsidised primary health and disability care as required by the MOH. The definition of 'residing in New Zealand' is that I intend to be living permanently in New Zealand for at least 183 days (6 months) in the next 12 months.
- I have been given information about the benefits and implications of enrolment with the PHO, and their contact details.
- I have read and I agree with the Health Information Privacy Statement.
- I agree to inform the practice of any changes in my eligibility.

✗	/ / *Day Month Year*
Signature*	***Date****

or signed of 'by Authority'

An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Full Name of Authority			
Phone		***Relationship***	
Address		***Detail the basis of authority*** *(eg parent of a child under 16)*	
Signature of Authority	✗		/ / *Day Month Year*

(Office Use only)

DOCTOR	ID Received	Process Date	Fax Date	Recpt Initials