

Tamaiti Whangai P.H.O. Trust ENROLMENT FORM

Encompassing the Medical Services of the Waiwhetu Medical Centre Group

Waiwhetu Medical Centre - Waiwhetu
148 Whites Line East, Waiwhetu

Waiwhetu Medical Centre - Petone
298 Jackson Street, Petone

PHO Enrolment Form Details:

I intend to use the Primary Health Organisation as my usual provider of primary health care services.

Please enrol me (or a child/children under 16 years who is/are under my custody or a dependant who is under my care) on your enrolment register.

1. What is your name?

Mr Mrs Ms Miss Dr (circle one)	
Family Name	
First Given Name	
Second Given Name	
Third Given Name	

2. Where do you usually live? *Note: this address must be a residential street address, not a post office box or private bag.*

Unit or Flat Number		Street Number		Street	
Suburb or Town					
City or Province					

3. When were you born?

_____ day / month / year

4. Are you male or female?

Male Female (circle one)

5. Are you a permanent resident of New Zealand?

Yes No (circle one)

6. Which ethnic group do you belong to? (Mark the space or spaces that apply to you. You may select up to 3.)

<input type="checkbox"/> NZ European	<input type="checkbox"/> Maori	Other (eg Dutch, Japanese, etc) Please state	
<input type="checkbox"/> Samoan	<input type="checkbox"/> Cook Island Maori		
<input type="checkbox"/> Tongan	<input type="checkbox"/> Niuean		
<input type="checkbox"/> Chinese	<input type="checkbox"/> Indian		

I understand that:

- this provider is a member of a Primary Health Organisation. I have been informed of the implications of enrolment with a Primary health organisation and I intend to use this Primary Health Organisation as my usual provider of primary health care services.
- for funding purposes the information on this form and contact information (ie the name of my provider and the date of my last visit), but not my health information, will be sent to the Ministry of Health.
- if I enrol with another Primary Health Organisation, my previous or 'old' Primary Health Organisation will be informed of this change. They will not be informed of the name of my new Primary Health Organisation.
- if I visit another provider, the Primary Health Organisation I am enrolled with will be informed of the date of this visit and my NHI number but will not receive the provider's name and my health information in relation to this visit.
- the information I have provided on this form will be used by the Ministry of health to give me a NHI number or update my NHI information.
- my health information, which will not include my name, may be sent to the Ministry of Health and may be used by District Health Boards to plan and fund future primary health care services.
- my primary health care provider may send my health information to other health professionals who are directly involved in my health care and treatment.

I declare the information I have given is true and complete as far as I know.

Signed: _____ **Date of Enrolment:** ____ / ____ / ____

For Office Use Only

NHI No.		
(if applic.) HUHC No.		Expiry Date:
(if applic.) CSC No.		Expiry Date: