Waihopai HEALTH SERVICES

Waihopai Health Services
1 Herbert St,
PO Box 6035 Invercargill
Ph 032110999 Fax 032110990
EDI: waihopai

REGISTRATION FORM

NHI*

Title	Mr Mrs Ms Miss Dr	**First Name(s)***		**Family Name***	
wPreferred Name				**Other Names Known By (e.g. maiden name)**	
Gender*	☐ **Male** ☐ **Female**			**Place / Country of birth***	
Physical Address* **Rapid Number as well as R.D. number please**	Street or Rapid (rural) number / Name of Street			**Date of Birth***	_____/_____/_____ **Day Month Year**
	Suburb				
	City/Town	Postcode			
Postal Address (If different from physical address)					

Contact Details	Day Phone	Night Phone	Mobile Phone	Email
Electronic Contact	I wish to be contacted by Text and /or Email for services that are due to me by Waihopai Health Services.		Tick one or both options-	☐ Text ☐ Email
Next of Kin	Name	Relationship	Contact number(s)	Address
Emergency contact	Name of person to contact	Relationship	Contact number(s)	Address

Which ethnic group do you belong to? * Mark the space or spaces which apply to you		**Please Circle Your Smoking Status**	Never Smoked	
			Smoker	Ex Smoker
Māori		**Enter any past medical history and other impairments or disabilities.**		
New Zealand European				
Samoan				
Cook Islands Maori				
Tongan		**Allergies- Please list any allergic reactions to medication or food**		
Niuean				
Chinese		**What was your reaction?**		
Indian		**Occupation(s)**		
Other such as DUTCH, JAPANESE, TOKELAUAN. Please state:				
Do you need an interpreter? ☐ Yes ☐ No		**Transfer of Records- In order to get the best care possible, I agree to the Practice obtaining my records from my previous**		

If Yes what Language?	**Doctor. I also understand that I will be removed from their practice register.** ☐ **yes** ☐ **No** ☐ **Not applicable**
Pharmacy:	Doctor's Name:
	Address/Location:

Registration at Waihopai Health Services.

Family Health	Has your Mother, Father, Brother, or Sister suffered from Diabetes, Cancer, High Blood Pressure, Heart Disease, Stroke, Kidney Disease or other serious health problem?		
Family Member E.g. Mother	**Condition/Illness** e.g. Heart attack	**Age at Onset** e.g.56	**Age at Death** e.g.72

Dependants listed on this form will also be registered in the practice					
NHI	**First Names**	**Family Name**	**Gender**	**Ethnicity/Ethnicities**	**Date of Birth**

I intend to use **Waihopai Health Services** as my regular and ongoing provider of general practice / GP / First Level primary health care services.

You may be eligible to enrol rather than register with the practice if you meet one of the following criteria.

If you meet one of the criteria please ask for an Enrolment Form.

I am eligible to enrol because **I live in New Zealand**[1] and meet one of the following criteria:

a) I am a New Zealand citizen **OR**

b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) **OR**

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 year **OR**

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) **OR**

e) I am an interim visa holder who was eligible immediately before my interim visa started **OR**

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 **OR**

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**

h) I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder **OR**

i) 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) **OR**

j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme **OR**

k) I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund.

I confirm that, if requested, I can provide proof of my eligibility.

My agreement to the Registration process
NB Parent or caregiver to sign if you are under 16 years

I choose to register with this practice as my regular and on going provider of general practice / GP / First Level primary health care services.

I **understand** that an administration fee will be charged to me if my account is unpaid by the last working day of each month.

I **understand** that if my account is outstanding after a further 30 days that the account may be passed to a collection agency and all fees associated with collection will be payable by me.

I have read and I agree with the Health Information Privacy Statement.

	/ /
SIGNATURE*	**DATE***

OR Signed by AUTHORITY[2]

Full Name of Authority	Contact Phone Number	Relationship
Address	Signature of Authority	/ /
Detail the basis of authority (e.g. parent of a child under 16):		

[1]The definition of residing in New Zealand is that you intend to be resident in New Zealand for at least 183 days in the next 12 months.

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

Health Information Privacy Statement
Registration Form

I understand the following:

Access to my health information

I have the right to access (and have corrected) my health information under Rules 6 and 7 of the Health Information Privacy Code 1994.

Visiting another GP

If I visit another GP who is not my regular doctor I will be asked for permission to share information from the visit with my regular doctor or practice.

If I have a High User Health Card or Community Services Card and I visit another GP who is not my regular doctor, he/she can make a claim for a subsidy, and the practice I am enrolled in will be informed of the date of that visit. The name of the practice I visited and the reason(s) for the visit will not be disclosed unless I give my consent.

Patient Registration Information

The information I have provided on the Practice Registration Form will be:

- held by the practice
- used by the Ministry of Health to give me a National Health Index (NHI) number, or update any changes
- sent to the PHO and Ministry of Health to obtain subsidised funding on my behalf if I am eligible
- 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.

Health Information

Members of my health team may:

- add to my health record during any services provided to me and use that information to provide appropriate care
- share relevant health information to other health professionals who are directly involved in my care

Audit

In the case of financial audits, my health information may be reviewed by an auditor for checking a financial claim made by the practice, but only according to the terms and conditions of section 22G of the Health Act (or any subsequent applicable Act). I may be contacted by the auditor to check that services have been received. If the audit involves checking on health matters, an appropriately qualified health care practitioner will view the health records.

Health Programmes

Health data relevant to a programme in which I am registered (e.g. Breast Screening, Immunisation, Diabetes) may be sent to the PHO or the external health agency managing this programme.

Other Uses of Health Information

Health information *which will not include my name but may include my National Health Index Identifier (NHI)* may be used by health agencies such as the District Health Board, Ministry of Health or PHO for the following purposes, as long as it is not used or published in a way that can identify me:

- health service planning and reporting
- monitoring service quality, and
- payment

Research

My health information may be used for health research, but only if this has been approved by an Ethics Committee and will not be used or published in a way that can identify me.

Except as listed above, I understand that details about my health status or the services I have received will remain confidential within the medical practice unless I give specific consent for this information to be communicated.