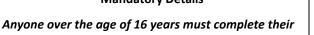
163 Colombo Street, Christchurch, 8023

Ph: 03 332 0108 Fax: 03 332 9354 EDI: chchsth

ENROLMENT FORM

August 2017

*Mandatory Details





own enrolment form **Christchurch South Doctor Name** NZMC: EDI: **Health Centre** *NHI (Office use only) Legal Name* (Title) *Given Name *Other Given Name(s) *Family Name Other Name (s) Other Name Other Given Name(s) Other Family Name (eg. maiden name) **Preferred Name** *Date of Birth *Place of Birth *Country of Birth Preferred Name Day / Month / Year of Birth Occupation Gender* П Male Female Gender diverse (please state) **Usual Residential** Address* House (or RAPID) Number and Street Name Suburb Town / City and Postcode **Postal Address** (if different from above) House Number and Street Name or PO Box Number Suburb Town / City and Postcode **Contact Details** Mobile Phone Home Phone **Email Address Emergency Contact*** Relationship Name Mobile (or other) Phone **Community Services Card** Yes No Day / Month / Year of Expiry Card Number **High User Health Card** Yes Day / Month / Year of Expiry Card Number If yes, would you like any support to quit? Smoking Status* Smoker Ex-Smoker Ex-Smoker **Never Smoked** Less than More than Yes No 15months ago 15months ago Ethnicity Details* New Zealand European Which ethnic group(s) do you belong to? Maori lwi: Tick the space or spaces Samoan which apply to you Cook Island Maori Tongan Niuean Chinese Indian Other (such as Dutch, Japanese, Tokelauan). Please state; In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. **Transfer of Records** I also understand that I will be removed from their practice register. Yes, please request transfer of my records No transfer Not applicable

Address / Location

Previous Doctor and/or Practice Name

| | | My declarat | ion of entitle | ment a | nd eligibilit | y* | | |
|---|--|---|--------------------------------|----------------|--------------------------|--------------------------|------------------|--|
| 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 | | | | | | | | |
| I am eli | gible to enrol bec | ause: | | | | | | |
| а | 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 | | | | | | | |
| If you a | re not a New Zeal | and citizen please tick w | hich eligibility criteria | applies to | vou (b–i) below: | | · | |
| b | I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) | | | | | | | |
| С | | stralian citizen or Australian permanent resident AND able to show I have been in New Zealand or stay in New Zealand for at least 2 consecutive years | | | | | | |
| 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) | | | | | | |
| е | I am an interim | im visa holder who was eligible immediately before my interim visa started | | | | | | |
| f | _ | 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 | • | m under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one terion 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 or child under 18 years old) | | | | | | neir 🔲 | |
| i | I am participatir | am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme | | | | | | |
| 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 | | | | | | | |
| I conf | irm that, if requ | ested, I can provide pr | oof of my eligibility* | : | Evidence | sighted <i>(Office</i> ι | use only) | |
| | | . • | ment to the e | | _ | : | | |
| | | | or Caregiver to sign i | - | | | | |
| I under | stand that by enr | ce as my regular and on- colling with this Practice tion) and my name addre ers. | I will be included in t | he enrolle | d population of Pe | gasus Health Cha | | |
| I under | stand that if I visit | another health care pro | vider where I am not e | enrolled I m | nay be charged a hi | gher fee. | | |
| | been given inform e PHO's name and | ation about the benefits contact details. | and implications of er | nrolment a | nd the services this | practice and PHC |) provides along | |
| used to | determine eligibi | ith the Use of Health Info lity to receive publicly-fo er the Privacy Act. | | | | | | |
| manage | ed. Taking part is v | actice participates in a n roluntary and all respons provides important inforr | es will be anonymous. | . I can decl | ine the survey or o | | | |
| I agree | e to inform the | practice of any chan | ges in my contact | details an | d entitlement and | d/or eligibility t | o be enrolled. | |
| Signat | ory Details* | Signature | | [| Day / Month / Year | Self Signing | Authority | |
| An autho | rity has the legal right | to sign for another person if f | or some reason they are un | nable to conse | ent on their own behalf. | | | |
| Autho (where s | rity Details signatory is not the g person) | Full Name | | | onship | Contact Phone | | |
| comily | 2 F | Basis of authority (e.g. parer | nt of a child under 16 years o | of age) | | | | |