New Brighton Health Care - Patient Enrolment Form

PHO: Pegasus Health (Charitable) Ltd

22 Union Street, New Brighton, Christchurch 8061, Ph 03 3887582 FX 03 388 7433

Name of General Practitioner you would like to enrol with:
NZMC EDI: brighton

(*) Mandatory information labelled with an asterisk must be completed

Personal Details: (If your details are not correct please update below)
Family Name*: Given Names*: NHI*:

Gender*: DOB*:

Place & Country of Birth*:
Iwi:

Physical Address: (requires a street address or Rapid address number, **not** PO Box or Private Bag)

Street*: Suburb*: City*: Christchurch Postcode*:

Postal Address (if different from physical address shown above)
Street/Private Bag/PO Box: ________________________ City: ________________ Postcode: _______

Phone Contacts: Home Phone: Work Phone: Mobile Phone:
Email address: Tick if you do not wish to receive SMS reminders and messages **[ ]**

Ethnicity* Which ethnic group do you belong to?
Mark the space or spaces that apply to you.
[ ] NZ European
[ ] Maori
[ ] Samoan
[ ] Cook Island Maori
[ ] Tongan
[ ] Niuean
[ ] Chinese
[ ] Indian
[ ] Other (such as Dutch, Japanese, Tokelauan). Please state: __________________ __________________

Community services card **[ ]**Yes **[ ]**No
Number: Exp date:

High use card **[ ]**Yes **[ ]**No
Number:123545 Exp date:13 Dec 2004

Emergency Contact Details*:
Name*: Relationship*: Contact Number*:

Smoking Status*:
[ ] Smoker **[ ]** Ex Smoker **[ ]** Never Smoked

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I intend to use this Practice as my regular & ongoing provider of general practice / GP / First Level primary healthcare services.

I am entitled to enrol because I am residing permanently in New Zealand **(**The definition, residing permanently in NZ, means that you intend to be resident in New Zealand for at least 183 days in the next 12 months.)

AND I am a New Zealand citizen [ ]

OR I meet the criteria I have circled below

A) Hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) **OR**

B) Am an Australian citizen or Australian permanent resident AND able to show that I have been in New Zealand or intend to stay in New Zealand for at least 2 consecutive years **OR**

C) 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**

D) Are an interim visa holder who was eligible immediately before their interim visa started **OR**

E) Am a refugee or protected person OR am in the process of applying for, or appealing refugee or protection status, OR am a victim or suspected victim of people trafficking **OR**

F) 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**

G) Am 18 or 19 years old and can demonstrate that, on 15 April 2011, I was the dependant of an eligible work visa/permit holder (visa must still be valid) **OR**

H) Am a NZ Aid Programme student studying in New Zealand and receiving Official Development Assistance funding (or their partner or child under 18 years old) **OR**

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

J) Am a Commonwealth Scholarship holder studying in New Zealand 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.
I agree to inform the Practice of any changes in my eligibility.

I understand that by enrolling with this Practice I will be enrolled with the Primary Health Organisation (PHO) this Practice belongs to and my name, address & other identification details will be included on both the Practice and the PHO Enrolment register.

I understand that if I visit another Provider where I am not enrolled, I may be charged a higher fee.
I have been given information about the benefits & implications of enrolment with the PHO & their contact details.

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

TRANSFER RECORDS FROM ANOTHER PRACTICE
In order to get the best coordinated healthcare, I ask this Practice to request that my medical records are transferred from my previous Practice. I understand that I will also be removed from the register of my previous Practice:
[ ] Yes Previous Practice Name: _____ **[ ]** No
[ ] Not applicable

Signed* : _____ Full name (Print): _____ **Date**

Relationship if not person shown on the form ie. Parent or legal guardian if you are under 16 years of age or legally authorised representative e.g. attorney, if the person is unable to consent on their own behalf.

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