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

Dr **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*: First Name*: Middle Names*:

Gender*: DOB*: NHI*:

Place & Country of Birth*: .....

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

Street*: Suburb*: City*: 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 Iwi .....
[ ] 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: Exp date:

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

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

If you are a smoker would you like support to quit [ ]

My declaration of entitlement and eligibility*

[]**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) Am 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[ ]. Evidence Sighted (Office Use Only) [ ]

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 the Practice, PHO and National Service Registers.
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.** The information I have provided on the Enrolment Form will be 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.
I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

Signature* : _____ **Date** [] Self Signing [] Authority

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

Authority details (where signatory is not the enrolling person)

Full name _____ Relationship _____ Contact phone

Basis of Authority (e.g. Parent or legal guardian if enrolling person is under 16 years of age or legally authorised representative e.g. Enacted Power of Attorney)

_____

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