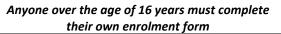
Northwood Medical Centre 324 Main North Road, Christchurch. 8051

Ph: 03 352 4875 Fax: 03 352 5617

ENROLMENT FORM

September 2018

*Mandatory Details





Practice Name*		Doctor NZMC		EDI: Northwod						
Northwood Medical Centre		ntre						*NHI (Office use only)		
Legal Name*										
Legai Name	(Title)	*Given Name		*Other Given Name(۵)	*Family Name				
Other Name (s)	` ′	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		outer Harrie		*Date of Birth		*Place of Birth *Country of Birth				
		Preferred Nan	ne 🗖	Day / Month / Year of Birth		Occupation				
Gender*				- di (alana atata)						
Male Female Gender diverse (please state)										
Usual Residenti	al									
Address*		House (or RAF	PID) Number and Street	Name Suburb		Town / City and		City and Postcode		
Postal Address (if different from above	٥١									
(ii different from above	e)	House Numbe	er and Street Name or P	O Box Number	er Suburb		Town / City and Postcode			
Contact Details										
		Mobile Phone	e Home	e Phone	Email Address					
Emergency Con	tact*									
		Name			Relationship		Mobile (or other) Phone			
Community Son	vicos Car	<u>,, </u>								
Community Services Card										
High User Healt	h Card	Yes	No Day / Month / Year of Expiry			Card Number				
ingii osci ricuit	cara	Yes	No.			Cond Number				
Smoking Status	*		S No Day / Month / Year of Expir			Card Number				
-		Smoke				Ex-Smoker	Ex-Sm	Never Smoked		
			Yes	No		Less than	More t	ORCI		
						15months ago	15mor	nths ago		
Ethnicity Details	s*	New	Zealand European							
Which ethnic group(s belong to?		buit								
Tick the space of										
which apply to you		Samoan								
		Cook	Cook Island Maori							
O Tong			gan							
	Niuean									
		Chine	ese							
		India	n							
	Other (such as Dutch, Japanese, Tokelauan). Please state;									
			, , , , , , , , , , , , , , , , , , , ,							
<u> </u>										
Transfer of Reco	ords		- :	_			cords f	from my previous Doctor.		
		I also understand that I will be removed from their practice register.								
	Yes, please request transfer of my			ny records		No transfer		lot applicable		
		Previous Doctor and/or Practice Name				Address / Location				

My declaration of entitlement and eligibility*											
	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 beca	ause:									
а	Ī										
If you a	re not a New Zeal	and citizen please tick which	eligibility criteria appl	ies to voi	u (b–i) below:						
b	1	dent visa or a permanent resident visa (or a residence permit if issued before December 2010)									
С	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 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 visa holder who was eligible immediately before my interim visa started										
f	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										
g	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 in the control of the Chief Executive of the Ministry of Social Development										
h	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)										
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme										
j	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 confirm that, if requested, I can provide proof of my eligibility* ☐ Evidence sighted (Office use only) ☐											
	My agreement to the enrolment process*										
		NB. Parent or C	aregiver to sign if yo	u are ur	nder 16 years						
I intend to use this practice as my regular and on-going provider of general practice / GP / health care services.											
I understand that by enrolling with this Practice I will be included in the enrolled population of Pegasus Health Charitable Ltd PHO (Primary Health Organisation) and my name address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers.											
I understand that if I visit another health care provider where I am not enrolled I may be charged a higher fee.											
I have been given information about the benefits and implications of enrolment and the services this practice and PHO provides along with the PHO's name and contact details.											
I have read and I agree with the Use of Health Information 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 understand that the Practice participates in a national survey about people's health care experience and how their overall care is managed. Taking part is voluntary and all responses will be anonymous. I can decline the survey or opt out of the survey by informing the Practice. The survey provides important information that is used to improve health services.											
I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.											
Signat	ory Details*	Signature		Day	/ Month / Year	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.											
(where	rity Details signatory is not the g person)	Full Name Relationship Contact Phone									
		Basis of authority (e.g. parent of a	a child under 16 years of age	·)							