peninsulamedical

382 Te Atatu Road, Te Atatu Peninsula

Title* Mr Mrs Mast Miss Dr Ms	Surname First Name(s)		**Preferred name** Other names known by (e.g. maiden name)	
NHI	Date of birth / /	**Gender** Male Female	**Place of birth** City/town	Suburb Country
Physical address* City/town Country Suburb Postcode			**Community Services Card** Yes ☐ No ☐ Card number Expiry date	
Postal address			**High User Health Card** Yes ☐ No ☐ Card number Expiry date	

Contact details	Day phone	Work phone	Cellphone	Email	**Do you agree to receive text messages?** * Yes ☐ No ☐

Emergency/ Next of Kin contact Name of person	Relationship to you	Phone number	Other contact details
Occupation	**Work address**		

Do you smoke? Yes ☐ No ☐ Never ☐ (ex-smoker)

Which ethnic group do you belong to? Mark the space or spaces which apply to you

New Zealand European		Maori		Cook Islands Maori		Tongan		Samoan	
Niuean		Chinese		Indian		Fijian		African	

Other such as DUTCH, JAPANESE, TOKELAUAN.
Please state:

Transfer of records:
Please complete transfer of record form.
I also understand that I will be removed from my previous practice register.

Sigature:

Dependants listed on this form will also be enrolled in the PHO as long as I am legally entitled to sign on their behalf (see below) Authorised representatives can enrol dependants. In the case of a dependant child under 16 years old, the process can be completed by a parent or caregiver who is the legal guardian or who has custody.

NHI *	First names *	Family name *	Gender *	Ethnicity/ Ethnicities *	Date of birth*	Country of birth *

PLEASE TURN OVER TO COMPLETE THIS FORM

ENROLMENT IN THE PRACTICE / PRIMARY HEALTH ORGANISATION (PHO)

I intend to use Peninsula Medical Centre 382 Te Atatu Road, Te Atatu Peninsula, Auckland, 0610.
as my regular and ongoing provider of general practice / GP / First Level primary healthcare services.

I am eligible to enrol because **I am residing permanently in New Zealand**.
I live in New Zealand and meet one of the following eligibility statements:***** (please tick)

☐ a. I am a New Zealand citizen (including those from Cook Islands, Niue or Tokelau) **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 i intend to stay in New Zealand for at least 2 consecutive years **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 is 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 New Zealand Aid Programme student studying in New Zealand 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 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.

MY AGREEMENT TO THE ENROLMENT PROCESS* (NB Parent or caregiver to sign if you are under 16 years)

I choose to enrol with this practice as my regular and ongoing provider of general practice / GP / First Level primary healthcare services.

I understand that by enrolling with this practice I will be enrolled with the Primary Health Organisation (PHO) ProCare this practice belongs to, and my name, address and 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 and implications of enrolment with the PHO, and their contact details.

I understand that my health information may be used for management & research purposes.
I have read and I agree with the Health Information Privacy Statement in accompanying PHO information.
I agree to inform the practice of any changes in my eligibility.

Signature* Signature of patient enrolling		**Date*** / /
OR Signed by authority**		
Full name of authority	**Contact phone number**	**Relationship**
Address	**Signature of authority**	**Date** / /
Detail the basis of authority (e.g. parent of a child under 16)		

* Mandatory to complete
** An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.
18/2/2014