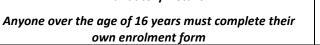
427 Marshland Road, Christchurch. 8083 Ph: 03 385 3114 Fax: 03 385 3113

EDI: gayhurst

## **ENROLMENT FORM**

August 2017

\*Mandatory Details





Practice Name <sup>*</sup>		Doctor Name			NZMC				
Marshlands Family Health Centre								*NHI (C	ffice use only)
		T		1		1			
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					
Gender*			7 7			Occupation			
		Male Female Gender diverse (please stat			)				
						1			
Usual Residenti	al								
Address*		House (or RAPID) Number and Street		Name Suburb		Towr		n / City and Postcode	
Postal Address									
(if different from abov	e)	House Number ar	nd Street Name or P	O Box Number	Suburb		Town	own / City and Postcode	
		T		1					
Contact Details									
•		Mobile Phone Home		e Phone	Email Address		l		
Emergency Contact*					Deletienskin		Adabile (a cable e) Phase		
		Name			Relationship		Mobi	Mobile (or other) Phone	
Community Services Card									
		Yes	Day / Month / Year of Expiry			Card Number			
High User Health Card				ivionitity real of Expiry	Care	211011001			
		Yes	No Day /	Month / Year of Expiry	Card	d Number			
Smoking Status*			Day /	ike any support to quit?				1	
		Smoker				Ex-Smoker E		<b>」</b> oker	Never Smoked
			Yes	No		Less than	More t		
					151	months ago	15mont	ns ago	
Ethnicity Detail	<u>*</u>	N722	land Francisco						
Which ethnic group(s		New Zealand European							
belong to?  Tick the space of	r spaces	Maori lwi:							
which apply to yo	-	Samoan							
		Cook Isla	ınd Maori						
		Tongan							
		Niuean							
		Chinese							
		Indian							
		Other (such as Dutch, Japanese,							
		Tokelaua	,						
<u> </u>									
Transfer of Rec	ansfer of Records In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I								vious Doctor. I
		also understand that I will be removed from their practice register.							
		Yes, please request transfer of my records			No transfer No			Not applicable	

Address / Location

Previous Doctor and/or Practice Name

		My declaratio	n of entitleme	ent an	d 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 e	<b>ligible to enrol</b> bec	ause:								
а										
If you	are <b>not</b> a <b>New Zeal</b>	and citizen please tick which	eligibility criteria appl	ies to you	ı (b–j) below:					
b	I hold a resident	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 v	isa holder who was eligible immediately before my interim visa started								
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		rears and in the care and control of a parent/legal guardian/adopting parent who meets one ises a—f above <b>OR</b> 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)									
i	I am participating	ting 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 con	<b>ifirm</b> that, if requ	ested, I can provide proof o	of my eligibility*		Evidence sig	ghted <b>(Office use</b>	only)			
		My agreeme	ent to the enr	olmen	nt process*	;				
			aregiver to sign if yo		<u> </u>					
	-	ce as my regular and on-goin								
Health	-	lling with this Practice I will be my name address and other i			_					
I unde	rstand that if I visit	another health care provider	where I am not enrol	led I may	be charged a hig	her fee.				
	<b>been given inform</b> ne PHO's name and	ation about the benefits and contact details.	implications of enrol	ment and	the services this	practice and PHC	provides along			
used to	_	vith the Use of Health Informa ity to receive publicly-funded e Privacy Act.			-					
manag	ged. Taking part is v	actice participates in a natio oluntary and all responses wil ides important information th	l be anonymous. I can	decline t	he survey or opt					
I agre	ee to inform the	practice of any changes	in my contact det	ails and	entitlement an	d/or eligibility t	o be enrolled.			
Signa	ntory Details*	Signature		Day	/ Month / Year	Self Signing	Authority			
An auth	ority has the legal right	to sign for another person if for sor	ne reason they are unable	to consent o	on their own behalf.					
(where	ority Details e signatory is not the ing person)	Full Name Relationship Contact Phone								
	· ·	Basis of authority (e.g. parent of a child under 16 years of age)								