peninsula medical

Title* Mr Mrs Mast Miss Dr Ms	**Legal Name** Surname First Name(s)		**Preferred name** Other names known by (e.g. maiden name)	
NHI	Date of birth / /	**Gender** Male Female **Gender diverse** (please State)	**Place of birth** City/town	**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	Mobile phone	Email	*Do you agree to Receive **text messages?** Yes No
Occupation	**Work address**			
Emergency/ Next of Kin contact Name of person	Relationship to you	Phone number	Other contact details	
Patient Survey: from time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.			Patient Survey contact details: As provided above	I do not wish to participate in the Patient Survey
Patient Survey: Alternative Email Address			Patient Survey: Alternative Mobile Phone	

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.

Signature:

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

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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 entitled to enrol because I am residing permanently in New Zealand. *The definition of residing permanently in NZ is that you intend to be a resident in NZ for at least 183 days in the next 12 months*		☐
I am eligible to enrol because:		
a	I am a New Zealand citizen (*if yes, tick the box and proceed to **I confirm that, if requested, I can provide proof of my eligibility** below)*	☐
If you are **not a New Zealand Citizen** please tick which eligibility criteria applies to you (b-j) below:		
b	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	☐
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	☐
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)	☐
e	I am an interim visa holder who is 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	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	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)	☐
I	I am participating in the Ministry of Education Foreign language Teaching Assistantship scheme	☐
j	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. ☐	Evidence Sighted *(Office Use Only)*

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.		