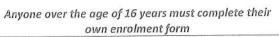


25 Deal Street, Kaikoura. 7300 Ph: 03 319 3500 Fax: 03 319 3513

ENROLMENT FORM

March 2018

*Mandatory Details





Practice Name*		Dr Bro	nwyn Lamond	NZMC 64291		EDI: kaikramc				
Kaikoura Healthcare		2. 2.2						*NHI (Office use only)		
Kalkoura Healthea	110							1		
Legal Name*							In the			
(Title)		#c N		*Other Given Name	cl	*Family Name				
		*Given Name		Other Given Name(s)		Talling Name				
Other Name (s)		out N		Other Given Name(s)		Other Family Name (eg. maiden name)				
Duefermed Name		Other Name		*Date of Birth		*Place of Birth *Country of Birth				
Preferred Name				Date of Birth		Trace or birer				
		Preferred Name		Day / Month / Year of Birth		Κ.				
Gender*		П	ПП			Occupation				
Gerrae.		Male Female Gender diverse (please state)								
		Wildle Te	,							
Usual Residential										
Address*		House for PADIO) Number and Street	Jame Suburb		b Town / Cir		City and Postcode		
Postal Address		House (or NAFID) Number and Street	ane		, tom,		and and restore		
(if different from above)			House Number and Street Name or PO Box Num			Town / City and Postcode		/ City and Postcode		
1		House Number a	and Street Name or P	O BOX Number	Box Number Suburb) Town / City and rostcod			
Cantact Datails										
Contact Details				01	Frank Address					
	alu	Mobile Phone	Home	e Phone	Email Ac	Email Address				
Emergency Conta	Emergency Contact*							e (ex ether) Phone		
		Name			Relation	ship	MODII	e (or other) Phone		
	C									
Community Service	ces car	d				2 2				
		Yes	No Day	/ Month / Year of Expi	ry C	ard Number				
High User Health Card										
		Yes	No Day	/ Month / Year of Expi		ard Number				
Smoking Status*		If yes, would you like any support			it?					
		Smoker				Ex-Smoker Ex-Smoker Never Sm				
		Yes No				Less than More than 15months ago 15months ago				
						Tallourille ago	LJIIIOIIII	13 850		
	- 1									
Ethnicity Details* Which ethnic group(s)		New Ze	aland European							
belong to?	do you	Maori Iwi:								
Tick the space or s	paces									
which apply to you		Samoan Are you happy to receive SMS Text messages? Yes No								
		Cook Isl	and Maori			8				
	1	Tongan								
	1	Niuean								
		Chinese	l .							
		Indian						*		
Other (such as Dutch, Japanese,										
Tokelauan). Please state;										
Transfer of Record	ds	In order to ge	et the best care p	ossible, I agree to	the Prac	tice obtaining my r	ecords ,	from my previous Doctor.		
		1 also unders	tand that I will be	e removed from the	eir practice register.					
		Yes, please	request transfer of r	my records	records No transfer Not a		t applicable			
		Previous Doctor and/or Practice Name				Address / Location				

Previous Doctor and/or Practice Name

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 e	ligible to enrol bec	ause:									
а											
If you	are <u>not</u> a New Zeal	and citizen please tick which eligibility criteria app	olies to yo	ou (b–j) below:							
b	I hold a resident	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	rim 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											
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*											
My agreement to the enrolment process* NB. Parent or Caregiver to sign if you are under 16 years											
I inten	d to use this practi	ce 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.											
Signa	natory Details*		Day / Month / Year		Self Signing	Auth	ority				
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	ority Details e signatory is not the				Contact Phone						
enrolling person)											

Basis of authority (e.g. parent of a child under 16 years of age)