Manuka Medical Ltd.
Trading as
Bryndwr Medical Rooms
Enrolment Form

378 Ilam Road Christchurch 8053	03 351 8169	EDI: bryndwrm	NHI *(Office use only)*

****Fields are compulsory (anyone over the age of 16 years MUST complete their own form)**

Name	(Title)	******Given Name	******Other Given Name(s)	******Family Name
Preferred Pronoun		Preferred Name	Other Name(s)	Maiden Name
****Birth Details**		Day / Month / Year of Birth	Place of Birth	Country of birth
****Gender**	☐ Male ☐ Female	☐ Another (please state)		Occupation

****Usual Residential Address**	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
Postal Address (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

Contact Details	Mobile Phone	Home Phone	Email Address	
Next of Kin				
****Emergency Contact**	Name		Relationship	Mobile (or other) Phone

Community Services Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number
High User Health Card	☐ Yes	☐ No	Day / Month / Year of Expiry	Card Number

****Transfer of Records**

In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I also understand that I will be ***removed from their practice register.***

☐ Yes, please request transfer of my records ☐ No transfer ☐ Not applicable

**Previous Doctor and/or Practice Name **Address / Location

**** Ethnicity Details**
Which ethnic group(s) do you belong to?

Tick the space or spaces which apply to you

An interpreting service is available if English is not your first language

Please see Receptionist for more information

☐ New Zealand European
☐ Maori
Iwi: _____
_____
☐ Samoan
☐ Cook Island Maori
☐ Tongan
☐ Niuean
☐ Chinese
☐ Indian
☐ Other (such as Dutch, Japanese, Tokelauan). Please state

Smoking Status (applies to 15 years & over)
Current Smoker ☐ Currently Vape ☐
Never Smoked ☐ Would you like support to quit? ☐ Yes ☐ No
Ex-smoker ☐ Quit date: _____

Are you happy to receive text messages to remind you about appointments and upcoming recalls? Yes ☐ No ☐

Preferred pharmacy: _____

Online Services
Would you like to register with our online service to book appointments, request prescriptions and view test results? Yes ☐ No ☐
To register, you must be over 16 and have your own unique email address.
Please confirm your email address below:

Primary language spoken:
English ☐ Other ☐ Please state:

**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 eligible to enrol because:

a	**I am a New Zealand citizen** *(If yes, tick 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 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 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	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 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	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 I can provide proof of my eligibility	☐	Passport	Birth Certificate
		Visa	CSC/Gold Card
		Evidence sighted (*Office use only*)	

My agreement to the enrolment process

NB: Parent or Caregiver to sign if you are under 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 if I visit another health care provider where I am not enrolled I may be charged a higher fee.

I understand that by enrolling with this Practice I will be included in the enrolled population of Waitaha Primary Health (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 my practice will have access to my Shared Care Records (HealthOne) from other health providers.

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 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 agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

** **Signatory 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

Authority Details *(where signatory is not the enrolling person)*	Full Name	Relationship	Contact Phone
	Basis of authority (e.g. parent of a child under 16 years of age)		