5 Kirk Road, ChCh. 8042 Ph: 03 349 6716 Fax: 03 349 8388 EDI: templetn	**ENROLMENT FORM** **March 2024** ***Mandatory Details** ***Anyone over the age of 16 years must complete their own enrolment form***	Pegasus™

Practice Name* **Templeton Medical**	**Dr Peter Wilkinson NZMC 10393**	*NHI *(Office use only)*

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		Preferred Name	***Date of Birth** Day / Month / Year of Birth	*Place of Birth	*Country of Birth
Gender*		☐ Male ☐ Female ☐ Gender diverse (please state)		Occupation	

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

Contact Details	Mobile Phone	Home Phone	Work Phone
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

Smoking Status*	☐ Smoker	If yes, would you like any support to quit? ☐ Yes ☐ No	☐ Ex-Smoker Less than 12months ago	☐ Ex-Smoker More than 12months ago	☐ Never Smoked

Ethnicity Details*
Which ethnic group(s) do you belong to?
Tick the space or spaces which apply to you

- ○ New Zealand European
- ○ Maori
- ○ Samoan
- ○ Cook Island Maori
- ○ Tongan
- ○ Niuean
- ○ Chinese
- ○ Indian
- ○ Other (such as Dutch, Japanese, Tokelauan). Please state;

Iwi: _____

Is your Emergency Contact also your Next Of Kin? Yes ☐ No ☐

If NOT enter Next of Kin Name and contact number below;

I have read and accept the Practice policies: Yes ☐

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	

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, 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 intend to use this practice 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.

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)		