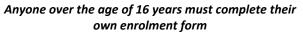
Waimairi Road Medical Practice

87 Maidstone Road Christchurch. 8041 Ph: 03 358 5535

ENROLMENT FORM

March 2024

*Mandatory Details





Dr James Wong	NZMC	29010				EDI: waimairi				
							*NI	HI (Office use only)		
Legal Name*										
_	(Title)	*Given Name		*Other Given Name	(c)	*Family Name				
Other Name (s)	· ,	Given Name		Other diverridance	(3)	ranny Name				
2		Other Name		Other Given Name(s)		Other Family Name (eg. maiden name)				
Preferred Name				*Date of Birth		*Place of Birth		*Country of Birth		
		- 6 1								
Gender*		Preferred Name	1 🗆	Day / Month / Year of Birth		Occupation				
Gender		Male Female Gender diverse (please state)								
		I Water Term	uic Genac	· urrerse (preuse state		l				
Usual Residential										
Address*		House (or RAPID) Number and Street Name			Suburb T		Town / Cit	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 Email Ad		dress				
Emergency Conta	ıct*									
		Name			Relationship		Mobile (or other) Phone			
Community Servi	ces Car	d 🔲	П							
	ces ca.	Yes		ay / Month / Year of Ex	niny	Card Number				
High User Health	Card			ay / Worth / Tear of E	рп у	cara ivanisci				
		Yes	<u></u>	ay / Month / Year of Ex	nirv	Card Number				
Smoking Status*				ou like any support to quit?						
	Smoker					Ex-Smoker	Ex-Smoker Never Smoked			
			Yes	No		Less than 12months ago 12	More th 2months ago			
						12months ago 12	inonthis age	0		
Ethnicity Details*		O New Zealand								
Which ethnic group(s) belong to?	do you	O Maori		lwi <i>:</i>						
Tick the space or s										
which apply to you		Samoan Are you happy to receive SMS Text messages? Yes No								
		Cook Islan	d Maori							
		○ Tongan								
		O Niuean								
		Chinese								
		Other (such as Dutch, Japanese,								
		(1)). Please state;							
Transfer of Recor	ds	_	•	_			cords froi	m my previous Doctor.		
				removed from th				1		
	Yes, please request transfer of r			ny records		No transfer Not applicable				
		Previous Doctor and/or Practice Name Address / Location								
		LIENIOUS DOCTOL SU	u, or Fractice NaM	-	Address / Location					

		My declarat	ion of entitler	nent and	deligibility	y *				
		ecause I am residing perr	•		33 days in the next 1	2 months				
I am eli	gible to enrol bec	ause:								
а	I am a New Zeala	and citizen (If yes, tick box	and proceed to I confirm t	hat, if requeste	d, I can provide pro	oof of my eligibility	below)			
If you a	re not a New Zeal	and citizen please tick w	hich eligibility criteria a	applies to you	(b–i) below:		·			
b	bu are <u>not</u> 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)									
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	n 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)						neir 🔲			
i	I am participatir	m 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 conf	irm that, if requ	ested, I can provide pr	oof of my eligibility*] Evidence	sighted (<i>Office</i> (use only) 🔲			
		. •	ment to the er		•					
1:-4			or Caregiver to sign i	-	· · · · · · · · · · · · · · · · · · ·					
I under	stand that by enr	ce as my regular and on- colling with this Practice tion) and my name addre ers.	I will be included in th	ne enrolled p	opulation of Peg	gasus Health Cha				
I under	stand that if I visit	another health care pro	vider where I am not e	nrolled I may	be charged a hig	gher fee.				
	een given inform e PHO's name and	ation about the benefits contact details.	and implications of en	rolment and t	the services this	practice and PHC) provides along			
used to	determine eligibi	ith the Use of Health Info lity to receive publicly-fo er the Privacy Act.								
manage	ed. Taking part is v	actice participates in a n roluntary and all respons provides important inforn	es will be anonymous.	I can decline	the survey or op					
I agree	e to inform the	practice of any chan	ges in my contact o	details and o	entitlement and	d/or eligibility t	o be enrolled.			
Signat	ory Details*	Signature		Day ,	/ Month / Year	Self Signing	Authority			
An autho	rity has the legal right	to sign for another person if f	for some reason they are un	able to consent o	on their own behalf.					
Autho (where s	rity Details signatory is not the g person)	Full Name Relationship Contact Phone								
2 0	o r/	Basis of authority (e.g. parer	nt of a child under 16 years o	f age)						