ONSLOW MEDICAL CENTRE - PATIENT ENROLMENT FORM

PATIENT DETAILS: (All fields marked with * must be completed)

Family Name:*		**Given Name/s:***	
Date of Birth:*		**NHI:**	
Gender:*	M ☐ F ☐ Other ☐	**Country of Birth:***	
If other gender please state:		**Place of Birth:***	
Address:*		**Postal Address:** *(if different from physical address)*	

Email:*			
Phone Number/s:*	(h)	(w)	(mob)
Smoking Status: *(please circle)*	**Current Smoker** ◯	**Ex-Smoker – Date Quit** ◯	**Never Smoked** ◯
Emergency Contact Person:		***Relationship to you:***	***Contact number:***
Community Services Card:	◯ **Y / N** ◯	***Expiry Date:***	*#:*
High User Card	◯ **Y / N** ◯	***Expiry Date:***	***#:***

*I am eligible to enrol in Compass PHO. I choose to use this Practice as my regular and on-going provider of general practice/GP/First Level primary health care services. I am eligible and entitled to enrol because I am residing permanently in New Zealand and I am a New Zealand Citizen ☐

OR meet one of the criteria laid out in the Eligibility Guide, with the corresponding letter: ☐

***Which ethnic group do you belong to?**

Tick the space or spaces that apply to you

▪ **New Zealand European**	◯
▪ **Maori – Name of IWI**	◯
▪ **Samoan**	◯
▪ **Cook Island Maori**	◯
▪ **Tongan**	◯
▪ **Niuean**	◯
▪ **Chinese**	◯
▪ **Indian**	◯
▪ **Other** (such as Dutch, Japanese, Tokelauan) *Please state:*	◯

- **I have read and 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 confirm** that if requested I can provide proof of my eligibility
- **I agree** to inform the Practice of any changes in my eligibility.
- **I understand** that by enrolling with this Practice, I will be enrolled with the Primary health Organisation (PHO) 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 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.

***SIGNED**: _____ ***DATE**: _____ I have signed the form ☐

or *SIGNED AUTHORITY: _____ ****DATE:***_____