PATIENT ENROLMENT FORM
Newlands Medical Centre & Compass Primary Health Care Network

***Must** be completed.

Patient NHI: ________________

1. Personal Details*

Title: Mr/Mrs/Ms/Miss/………..........

Family Name:*

Given Name/s:*

Preferred Name:

Maiden Name:

Date of Birth*: __ __ / __ __ / __ __ __ __

Gender:* Male ☐ Female ☐

2. Contact Details*

PHYSICAL ADDRESS:*

Unit/House No:

Street:

Suburb:

Town/City:

Postcode:

Home Phone: (0)

Work Phone: (0)

Mobile Phone:

POSTAL ADDRESS: (Complete if different from Physical Address)

CONSENT to use text messaging: **Yes / No**

PO Box/Unit/House No:

Street:

Suburb/Rural Delivery:

Town/City:

Postcode:

Email Address:

CONSENT to use email : **Yes / No**

3. Community Health Details*

Community Services Card Number:

Expiry Date: / /

Sighted: (Office Use Only) Yes ☐ No ☐

High User Health Card No:

Expiry Date: / /

Sighted: (Office Use Only) Yes ☐ No ☐

4. Ethnicity*

Which ethnic group do you belong to? (Mark the space or spaces that apply to you):*

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

5. Country of Birth:*

6. Next of Kin/Emergency Contact Details*

First and Family Name:*

Relationship to you:

PHYSICAL ADDRESS:

Unit/House No: **Street:**

Suburb & City:

Day Phone *: (0)

Mobile Phone *: 0

I AM ELIGIBLE TO ENROL IN COMPASS PRIMARY HEALTH CARE NETWORK.

7. Smoking Status:

Smoking status is an important factor influencing health. Please tick the space that applies to you.

☐ Never smoked ☐ Ex-Smoker ☐ Currently a smoker

8. Signed DECLARATION*

I intend to use NEWLANDS MEDICAL CENTRE as my regular and ongoing provider of general practice / GP / First Level primary health care services.

I am eligible and entitled to be enrolled in this PHO as I am residing in New Zealand and meet one of the following criteria (PLEASE CIRCLE):

a) I am a New Zealand citizen **OR**

b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) **OR**

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 **OR**

d) I have a work visa/permit and can show that I am able to be in New Zealand for at least 24 months (previous permits included) **OR**

e) I am an interim visa holder who was eligible immediately before my interim visa started **OR**

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 **OR**

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**

h) I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder **OR**

i) 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) **OR**

j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme **OR**

k) 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

- **I intend to use this PHO as my preferred provider of Primary Health Services**
- **I understand** that by enrolling with this practice I will be enrolled with **Compass Primary Health Care Network,** which is the Primary Health Organisation this practice belongs to, and my name, address and other identification details will be included on both the Practice and the **Compass Primary Health Care Network** Enrolment Register.
- **I understand** that if I visit another provider where I am not enrolled I may be charged a higher fee.
- **I have read and I agree** with the **Health Information Privacy Statement**.
- **I agree** to inform the practice of any changes in my eligibility.
- **I understand** that Newlands Medical Centre may charge for missed appointments.
- **I understand** that payment is expected at the time of the visit. An accounting fee will be added to unpaid accounts and any debt collection costs incurred will be my responsibility.

SIGNATURE:* ______________________________ **Date Of Signature:*** ____/____/______

***How did you hear about us?** Family/friend recommendation ……. / Internet ….. / Printed advertisement/flyer ……..

OR Signed by AUTHORITY

Name of Authority: ______________________ **Relationship:** ______________________

Address: ______________________

Contact Phone Number: ______________________

An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.