CompassHealth
Working together, towards healthy and flourishing communities

CAPITAL CARE HEALTH CENTRE

# PATIENT ENROLMENT FORM

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

| | | | |
|---|---|---|---|
| **Surname:*** | | **Title:** | |
| **Given Names*** | | **D.O.B*** | / / |
| **Gender:*** | **M** ☐ **F** ☐ **Gender Diverse** ☐ please state below: | **Country of Birth:*** | |
| | | **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** | **Never Smoked** |
| **Emergency Contact:** | | ***Relationship:*** | ***Contact number:*** |
| **Community Services Card:** | **Y/N** | ***Exp:*** | *#:* |
| **High User Card** | **Y / N** | ***Exp:*** | ***#:*** |

*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: ☐

- **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.

***SIGNED**: _____ ***DATE**: _____

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

***RELATIONSHIP TO PATIENT:*** _____

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

*Tick the space or spaces that apply to you*

| | |
|---|---|
| ▪ **New Zealand European** | |
| ▪ **Maori** | |
| ▪ **Samoan** | |
| ▪ **Cook Island Maori** | |
| ▪ **Tongan** | |
| ▪ **Niuean** | |
| ▪ **Chinese** | |
| ▪ **Indian** | |

▪ **Other** (such as Dutch, Japanese, Tokelauan) *Please state:*

***Patient Survey**

From time to time we may contact you and ask for your feedback on your experience of care. This provides important information which we use to improve health services. Participation is voluntary and anonymous.

☐ **Yes** I am happy to participate

☐ **No,** I do not wish to participate

**Patient Survey contact details:**

As provided above ☐

Or alternative mobile or email: