**PATIENT ENROLMENT FORM – COMPASS HEALTH PHO**

 **\*Personal Details:-**

 **\*Contact Details:-**

**Title:**

**Family Name:**

**First Name/s:**

**Preferred Name:**

16+ yrs contact by txt? Yes or No

**{;**

**Patient NHI**

YYesYYes

**Date of Birth**

**Gender:**

**Male**

**Female**

**/**

**/**

**PHYSICAL ADDRESS:**

**Unit / House No:**

**Street:**

**Work Phone:**

**Home Phone:**

**Mobile Phone:**

)

(0

)

(0

**Suburb:**

**Town or City:**

**Postcode:**

**Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**POSTAL ADDRESS:** (Complete if different from physical address)

**PO Box or Address: Town or City: Postcode:**

|  |  |  |
| --- | --- | --- |
|  **\*Ethnicity:-**  |  |  |

**Country of Birth:**

**Which ethnic group do you belong to? (You may select more than one ethnicity):**

* New Zealand European
* Maori
* Samoan
* Cook Island Maori / Tongan
* Chinese
* Indian
* Other (such as Dutch, Niuean, Japanese, Tokelauan)

**\*Next of Kin / Emergency Contact Details:-**

**First and Family Name:**

**Phone: Relationship:**

**SIGNED AUTHORITY – THE FOLLOWING MUST BE COMPLETED**

**I AM ELIGIBLE TO ENROL IN COMPASS HEALTH PHO**

I intend to use **Churton Park Medical Care** 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 as appropriate:***

1. I am a New Zealand citizen **OR**
2. I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) **OR**
3. 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**
4. 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) **OR**
5. I am an interim visa holder who was eligible immediately before my interim visa started **OR**
6. 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**
7. 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**
8. I am under 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**
9. 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**
10. I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme **OR**
11. I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a NZ University under the Commonwealth Scholarship and Fellowship Fund. I can 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 Health,** 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 Health** 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

**SIGNATURE:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **/** |  |  | **/** |  |  |

Date of Signature:

OR **SIGNED** BY AUTHORITY:…………….......................

Name of Authority (Parent/Guardian):

…………………………………………………………………............

Contact Phone Number:………………………………………

Relationship:………………………………………………………………….....................

1An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

**A separate enrolment form is required for each patient including dependants.**

**People 16 years or over are to complete and sign their own form**

**reception@cpmc.co.nz**