Tawa Medical Centre Ltd

PATIENT ENROLMENT FORM

A separate enrolment form is required for each patient including dependents, and people 16 years or over are to complete and sign their own form.
*Must be completed.

1. PERSONAL DETAILS:
TITLE: FAMILY NAME:*
FIRST NAME/S: * PREFERRED NAME: Patient NHI:
DATE OF BIRTH: *
ACCOUNT HOLDER: Yes / No (please circle) GENDER: * Male / Female (please circle)

2. CONTACT DETAILS:
UNIT NUMBER & STREET:*.
SUBURB:
WORK PH: MOBILE PH: .TOWN/CITY: HOME PH:
POSTAL ADDRESS:(if different from above) PO BOX/Unit/House No/Street: SUBURB/RURAL DELIVERY:
TOWN/CITY: POST CODE:
PREFERRED CONTACT METHODS: (please circle as many as are appropriate) Text EMAIL ADDRESS:
Cell Phone Post Landline

3. ETHNICITY
Which ethnic group do you belong to? Tick the space or spaces that apply to you
☐NZ European ☐Tongan ☐ Maori ☐ Niuean
☐ Samoan ☐ Chinese ☐Cook Island Maori ☐Indian
☐ Other (such as Dutch, Japanese, Tokelauan) please state: ______________

4. COUNTRY OF BIRTH*: ______________________
5. COMMUNITY HEALTH DETAILS
Community Services Card Number: Expiry Date: Sighted: (Office use only)
_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ ___/___/___ Yes / No
High User Health Card Number: Expiry Date: Sighted: (Office use only)
_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ ___/___/___ Yes / No

6. NEXT OF KIN / EMERGENCY CONTACT DETAILS
Name:. Relationship:
Address:

Contact Numbers:

8. SMOKING STATUS
Smoking status is an important factor influencing health. Please circle the option that applies to you. (If you are aged 15 years and over).
Never Smoked Ex-Smoker- (date given up)..................................Current smoker (do you want advice) Yes/No

SIGNED AUTHORITY*
I AM ELIGIBLE TO ENROL IN COMPASS PRIMARY HEALTH CARE NETWORK
I choose to use this Practice as my regular and ongoing provider of general Practice/GP/First Level primary health care services. CIRCLE ONE - I am eligible and entitled to enrol because I am residing Permanently in New Zealand and I am a New Zealand Citizen OR - meet meet one of the criteria in the Eligibility Guide, with the corresponding letter:
I confirm that, if requested, I can provide proof of my eligibility.
MY AGREEMENT TO THE ENROLMENT PROCESS

- 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 eligibilty.

SIGNATURE: * ______________________DATE:* ___/___/___
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.