Drs Cammack & Evans

Paraparaumu Beach

PATIENT ENROLMENT FORM

(All fields marked with * must be completed)

Surname*:		**Title:**	
Given Names*:		**D.O.B***	
Gender*:		**Country of Birth:***	
	If Gender Diverse please state	**Place of Birth:***	
Address:*		**Postal Address:**	
Email:*			
Phone Number/s:*	**Home: Work: Mobile:**		
Smoking Status:	**Never Smoked:** ☐ **Ex-smoker:** ☐ **Current smoker:** ☐		
Emergency Contact:		***Relationship:***	***Contact number:***
Community Services Card:	**Number: Expiry:**		
High User Card	**Number: Expiry:**		

- *I am eligible to enrol in Compass PHO. I choose to use Drs Cammack & Evans as my regular and on-going providers 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
  - I 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.

***To which ethnic group do you belong?**

NZ European.............. ☐
Maori .... ☐
Samoan .... ☐
Cook Island Maori ..... ☐
Tongan .... ☐
Niuean .... ☐
Chinese .... ☐
Indian .... ☐
Other – 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'm happy to participate
☐ No I don't wish to participate

*Signed:______________________________ *Date: _________

or *Signed authority: ___________________ *Date: _________ Relationship: ________________