



# CARING CLINIC DOCTORS ENROLMENT FORM



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Title 称呼		*First Name(s)名	*NHI 医疗号	
Preferred Name 惯用名		*Family Name 姓		
*Gender 性别 <input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女 <input type="checkbox"/> Gender Diverse (please state) 其他		*Date of Birth 出生日期 ____/____/____ Day 日 Month 月 Year 年		
*Physical Address 住址 Street number 门牌号 _____ Name of Street 街道名 _____ Suburb 地区 _____ City/Town 城市 _____ Postcode 邮政编码 _____		*Place & Country of birth 出生城市、国家		
Occupation/职业		*High User Card 高危病人卡 Card Number & Expiry Date 卡号及过期日		
Postal Address 通信地址 <input type="checkbox"/> tick if same as above 同上请打勾		YES 有 / NO 没有		
Community Services Card 社区服务卡 Card Number 卡号		YES 有 / NO 没有		
Contact Details 联系方式 Day Phone 工作电话 _____ Night Phone 住宅电话 _____		Mobile No 手机 _____ (Tick box to accept txts) <input type="checkbox"/> 同意接收短信请打勾		
Email 电子邮箱 _____ (Tick box to accept emails) <input type="checkbox"/> 同意接收邮件请打勾		Emergency contact 紧急联络人 Name of person to contact 联系人姓名 _____ Relationship 关系 _____ Phone number 电话 _____		

*Which ethnic group do you belong to? 你属于哪个种族? Tick the space or spaces which apply to you 请打勾		Smoking Status 吸烟状况		*Eligibility (see over page) 资格 (见背面) I confirm that, if requested, I can provide proof of my eligibility 我可以证实, 如果被要求的话, 我可以提供我的资格证明 I agree to inform the practice of any changes in my eligibility 我同意通知诊所如果我的资格有任何改变	
<input type="checkbox"/> 11 New Zealand European		<input type="checkbox"/> Current 吸烟者		*Eligible under criteria 符合资格的条件 (enter applicable letter from list over page (请从背面列表选择合适的字母))	
<input type="checkbox"/> 21 Māori Iwi:		<input type="checkbox"/> Ex-Smoker 戒烟者		*I have read and agree to the Enrolment Process, the Health Information Privacy Poster/Statement, and Patient Experience Survey(tick).我已阅读并同意注册过程, 健康信息隐私声明及患者就医调查(请打勾).	
<input type="checkbox"/> 31 Samoan		<input type="checkbox"/> Never Smoked 从不吸烟		<input type="checkbox"/> Not Eligible 没有资格 (Tick if not eligible under any criteria over page 请打勾)	
<input type="checkbox"/> 32 Cook Islands Maori					
<input type="checkbox"/> 33 Tongan					
<input type="checkbox"/> 34 Niuean		Transfer of Records 移交医疗记录 <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 <input type="checkbox"/> Not applicable 没有			
<input type="checkbox"/> 35 Tokelauan		In order to get the best care possible, I agree to the transfer of my records from my previous Doctor. I understand, I will be removed from their practice register. 我同意此诊所从我之前的家庭医生获得我的历史病例。我也明白, 此后我将不再是前家庭医生的注册病人了。			
<input type="checkbox"/> 42 Chinese 华人		Doctor's Name 前家庭医生的姓名:			
<input type="checkbox"/> 43 Indian		Address / Location 前家庭医生的诊所地址:			
<input type="checkbox"/> 54 Other such as DUTCH, JAPANESE Please state:		Phone/Fax 前家庭医生的电话/传真:			
*SIGNATURE 签名				*DATE 日期	
				____/____/____ Day 日 Month 月 Year 年	

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

Full Name of Authority 授权人姓名:	Contact Phone Number 联系电话:	Relationship 亲属关系:
Address 住址:	Signature of Authority 授权人签名:	____/____/____ Day 日 Month 月 Year 年
Detail the basis of authority (e.g. parent of a child under 16):		

Please read and identify on your enrolment form which criteria provides your eligibility to funded health services

I am entitled to enrol because **I am residing permanently in New Zealand** (intend to be resident in NZ for at least 183 days in the next 12 months) and meet **one** of the following criteria:

我符合注册的标准因为我永久居住在新西兰(打算在之后的 12 个月之内在新西兰居住至少 183 天), 同时我符合下列中的:

a) I am a New Zealand citizen 我持有新西兰护照	<b>OR</b>	Yes / No
b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) 我持有新西兰居民或者永久居民签证	<b>OR</b>	Yes / No
c) I am an Australian citizen or Australian permanent resident <b>AND</b> able to show I have been in New Zealand or intend to stay in New Zealand for at least 2 consecutive years 我持有澳大利亚护照或澳大利亚永久居留证, 并且我能出示我已经或者我将在新西兰居留至少两年	<b>OR</b>	Yes / No
d) 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) 我持有新西兰合法工作签证证明我可以在新西兰工作至少两年	<b>OR</b>	Yes / No
e) I am an interim visa holder who was eligible immediately before my interim visa started 我持有临时护照, 在得到临时护照即时之前我是符合注册标准的	<b>OR</b>	Yes / No
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 我是一位难民或者受到避难或者在申请的过程中, 或者正在上诉, 恳求成为难民和避难, 或者是受害人或被怀疑是人口贩卖的受害人	<b>OR</b>	Yes / No
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 我 18 岁以下, 我的父母/监护人/领养父母, 符合以上 a-f 中的任何一条	<b>OR</b>	Yes / No
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 我年满 18 或 19 并可证明 2011 年 4 月 15 日时我持有有效的工作签证	<b>OR</b>	Yes / No
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) 我是一个新西兰援助计划的学生在新西兰学习并接受官方发展援助资金 (或者我的伴侣是一个新西兰援助计划的学生, 或者我未满 18 并且父/母是一个新西兰援助计划的学生)	<b>OR</b>	Yes / No
j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme 我参加教育部外语教学助教奖学金计划	<b>OR</b>	Yes / No
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 我是英联邦奖学金持有人在 新西兰学习并且从新西兰大学接收英联邦奖学金或奖学金基金颁发的资金		Yes / No

**I confirm that, if requested, I can provide proof of my eligibility.**

我确认, 如果有需要, 我可以提供我符合注册标准的证明

#### My agreement to the enrolment process 注册同意书

NB Parent or caregiver to sign if you are under 16 years 需父母或监护人签字如果您未满 16 岁

✓ I choose to enrol with this practice as my regular and ongoing provider of general practice/GP/first level primary health care services.

我选择此家庭医生诊所作为我的医疗提供者/家庭医生/基本卫生保健服务

✓ 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.

我明白在此诊所注册的同时我也将在诊所归属的基本卫生保健服务机构注册。我的名字, 地址以及其它身份证明将被保留在此诊所和此机构。

✓ I understand that if I visit another provider where I am not enrolled I may be charged a higher fee.

我明白如果我去除此诊所以外的其它诊所, 我可能会被要求支付更高的诊金。

✓ I have been given information about the benefits and implications of enrolment with the PHO, and their contact details.

我已经得到关于此基本卫生保健服务机构注册将提供给我的优待及福利以及他们的联系方式

✓ I have read and I agree with the Health Information Privacy Statement in accompanying PHO information pamphlet.

我已阅读并同意此基本卫生保健服务机构注册的健康信息隐私权声明信息。

✓ I agree to inform the practice of any changes in my eligibility.

我同意如果我的资格证明有任何变动我会通知诊所