

ENROLMENT FORM



DW Family Doctors

177 Pakuranga Road
 Pakuranga, Auckland 2010
 Phone: 09 576 5177 Fax: 09 576 5178
 EDI: dwdoctor



					NHI*
Title (称呼)	Mr Mrs Ms Miss Dr	First Name(s)* (名)	Family Name*(姓)		
Preferred Name (喜欢的称谓)			Other Names Known By (e.g. maiden name) (其他的名字)		
Gender (性别)*	Male(男)	Female(女)		Place / Country of birth (出生地)*	
Physical Address* (家庭住址):	Street or Rapid (rural) number (号)	Name of Street (街名)		Date of Birth (生日)*	____/____/____ Day(日) Month(月) Year(年)
	Suburb(区名)		Community Services Card (社区服务卡)	YES / NO	
	City/Town(城市名)	Postcode(邮编号码)		Card Number Expiry Date	
	Postal Address (邮寄地址):			High User Health Card (健康卡)	YES / NO
Contact Details (联系方式)			Day Phone (日间电话):	Night Phone(夜间电话):	Cell Phone (手机):
Emergency contact (紧急联络):	Name of person to contact (联系人):	Relationship(关系):	Phone number(电话):	Other contact details (其他联络方式):	
Which ethnic group do you belong to?(种族)* Mark the space or spaces which apply to you(请打勾)			Smoking Status Please tick one of the options below The Ministry of Health requires us to record your smoking status. (吸烟状况) 卫生部需要我们记录注册病人的吸烟状况.		
New Zealand European			Never Smoked (从不吸烟)		
Māori			Current Smoker(现吸烟者)		
Samoan			Ex-smoker (12 Months+)(曾经吸烟,戒烟超过 12 个月以上)		
Cook Islands Maori			Ex-smoker (under 12 Months)(曾经吸烟,戒烟未满 12 个月)		
Tongan			Transfer of Records (同意转移病史记录)		
Niuean			In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register. (请选择)		
Chinese			Yes No Not applicable		
Indian			Doctor's Name (前任医生):		
Other such as DUTCH, JAPANESE, TOKELAUAN. Please state:			Address / Location(诊所地址):		
			SIGNATURE(签名)*:		DATE(日期)*:

See page 2- for eligibility, consent and signature (请翻至反面)

STAFF USE ONLY	Entered	Faxed	Scanned	NHI found	Checked
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Enrolment in the Practice / Primary Health Organisation (PHO)

I intend to use **DW Family Doctors** as my regular and ongoing provider of general practice / GP / First Level primary health care services.

I am entitled to enrol because I am residing permanently in New Zealand¹ and meet one of the following criteria:

a) I am a New Zealand citizen (新西兰公民) OR(或)	Yes / No
b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) (新西兰居留或永久居留者)(或 2010 年以前签发的居留者)	Yes / No
c) 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(在新西兰居住至少两年的澳洲公民或将永久居民)	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)(拥有工作签证并可以在新西兰居住至少两年者)	Yes / No
e) I am an interim visa holder who was eligible immediately before my interim visa started	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	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	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	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)	Yes / No
j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	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.	Yes / No

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

My agreement to the enrolment process

NB Parent or caregiver to sign if you are under 16 years

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

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.

I have read and I agree with the Health Information Privacy Statement (overleaf).

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

I understand that the practice participates in a national survey about people's health care experience and how their overall care is managed. Taking part is voluntary and all responses will be anonymous. I can decline the survey or opt out of the survey by informing the practice. The survey provides important information that is used to improve health services.

I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

	/ / Day(日) Month(月) Year(年)
SIGNATURE (签名)*	DATE(日期)*

OR Signed by AUTHORITY (或由授权人签名)²

Full Name of Authority(授权人)	Contact Phone Number(电话)	Relationship(关系)
Address(地址)	Signature of Authority(签名)	/ / Day(日) Month(月) Year(年)
Detail the basis of authority (e.g. parent of a child under 16)(授权理由) (比如:16 岁以下小孩的父母):		

¹ The definition residing in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months

² An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.