

87 Maidstone Road Christchurch, 8041 Ph: 03 358 5535 Fax: 03 358 5753 EDI: waimairi	ENROLMENT FORM 註冊登記表 2017 * Mandatory details *必須填寫的部份 Any one over the age of 16 years must complete their own enrolment form 十六歲以上的人士必須自己填寫表格	
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Practice Name 診所名 Waimairi Road Medical Centre	Dr James Wong NZMC 29010 NHI (Office use only)
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*Legal Name 官方(英文)姓名 (Title)	*Given Name 名字	*Other Given Name(s)	*Family Name 姓
Other Name 其他名字	Other Name 其他名字	Other Given Name(s)	Other Family Name (eg. maiden name) 其他姓
Preferred name 希望被叫的名字	Preferred Name 希望被叫的名字	*Date of Birth 出生日期 Day / Month / Year of Birth	*Place of Birth 出生地 *Country of Birth 出生國家
*Gender 性別	<input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女 <input type="checkbox"/> *Gender diverse 其他	Please state if gender diverse 若是其他請說明	Occupation 工作

*Usual Residential Address 家庭地址	House (or RAPID) Number and Street Name 號碼和街名	Suburb 地區	Town / City and Postcode 城市和郵編
Postal Address 郵寄地址	House Number and Street Name 號碼和街名 or PO Box Number (號碼)	Suburb 地區	Town / City and Postcode 城市和郵編

Contact Details 聯絡方式	Mobile Phone 手機號碼	Home Phone 家里電話	Email Address 電郵
*Emergency Contact 緊急聯絡	Name 姓名	Relationship 與本人關係	Mobile (or other) Phone 聯繫電話

Community Services Card 社區服務卡	<input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有	Expiry Date 到期日	Card Number 號碼
High User Health Card 高頻率看病卡	<input type="checkbox"/> Yes 有 <input type="checkbox"/> No 沒有	Expiry Date 到期日	Card Number 號碼
*Smoking Status 是否吸煙 14 years over 14 歲以上	<input type="checkbox"/> Smoker 是	Would you like any support to quit? 您是否需要幫助戒煙 <input type="checkbox"/> Yes 需要 <input type="checkbox"/> No 不需要	<input type="checkbox"/> Ex-smoker less than 15 months ago 15 個月內曾吸煙 <input type="checkbox"/> Ex-Smoker more than 15 months ago 15 個月前曾吸煙 <input type="checkbox"/> Never Smoked 不曾吸煙

*Ethnicity Details 民族 Which ethnic group(s) do you belong to? 您屬於那一個民族? Tick the space or spaces which apply to you 請將適合你的選項標示出來	<input type="radio"/> New Zealand European 歐裔紐西蘭人 <input type="radio"/> Maori 毛利人 <input type="radio"/> Samoan 薩摩亞人 <input type="radio"/> Cook Island Maori 庫克島毛利人 <input type="radio"/> Tongan 東加人 <input type="radio"/> Niuean 紐埃人 <input type="radio"/> Chinese 中國人/ 華人 <input type="radio"/> Indian 印度人 <input type="radio"/> Other 其他民族(such as Dutch, Japanese, Tokelauan). Please state; <input type="text"/>	Iwi : Are you happy to receive SMS Text Messages? 你是否願意收來自診所的短信 Yes 是 <input type="checkbox"/> No 不是 <input type="checkbox"/>
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Transfer of Records 醫療記錄轉移	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. 為了使我的醫療記錄得以銜接, 我同意此間診所把我所有醫療記錄從原先診所轉出。我也了解原先診所將會把我在他們的註冊上除名
<input type="checkbox"/> Yes, please request transfer of my records 同意轉移 <input type="checkbox"/> No transfer 不同意轉移 <input type="checkbox"/> Not applicable 不相關	Previous Doctor and/or Practice Name 原先診所的名稱 Address / Location 原先診所的地址

*My declaration of entitlement and eligibility 我对我注册资格和权利所做的宣告

I intend to use this practice as my regular and on-going provider of general practice / GP / health care services. 我將長期使用此間診所為我所提供的家庭醫生醫療服務	<input type="checkbox"/>
I am entitled to enrol because I am residing permanently in New Zealand. <i>The definition of residing permanently in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months</i> 我有權利因為我在紐西蘭長期居住我打算在未來的十二個月至少住上一百八十三天	<input type="checkbox"/>

I am eligible to enrol because:

a	I am a New Zealand citizen (If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below) 我是紐西蘭公民	<input type="checkbox"/>
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If you are **not** a New Zealand citizen please tick which entitlement criteria applies to you (b-j) below:

b	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) 我有居民簽證或是永久居民簽	<input type="checkbox"/>
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 我是澳洲公民或有澳洲永久居民簽證和我能夠証我已經或打算持續在紐西蘭住上至少兩年	<input type="checkbox"/>
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) 我有工簽或是工作准証和我可以証明我能夠在紐西蘭住上至少兩年(過去的准証可以包括。)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started 我有臨時簽證並能在簽證開始前有權利註冊	<input type="checkbox"/>
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 我是難民或是被保護人人士或是正在申請難民被保護身份或是人口販賣的受害者或是被你疑為人口販賣的受害者	<input type="checkbox"/>
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 and control of the Chief Executive of the Ministry of Social Development 我的年齡是十八歲以下，但照顧我的父母/堅護人/養父母滿足 a 到 f 其中一個條件和我是在社會發展部首席執行官的管制	<input type="checkbox"/>
h	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) 我是紐西蘭航空計劃的學生並且接受官方發展援助資金 (或是他們的伴侶或是他們十八歲以下的小孩)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme 我參與教育部外語助教計劃	<input type="checkbox"/>
j	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund 我有英聯邦獎金並在紐西蘭大學就讀。我在英聯邦獎學金下領取從紐西蘭大學所給予的資助。	<input type="checkbox"/>

*I confirm that, if requested, I can provide proof of my eligibility 若被要求，我能夠提供與我註冊資格有關的憑據和資料	<input type="checkbox"/>
Evidence sighted (office use only) 憑據和資料已被檢驗 (官方使用)。	<input type="checkbox"/>

***My agreement to the enrolment process 我註冊过程的协议**
NB. Parent or Caregiver to sign if you are under 16 years (您若是十六岁以下，請父母或是堅护人帶签)

I understand that by enrolling with this practice I will be included in the enrolled population of the Primary Health Organisation (PHO) this practice is contracted to, and my name address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers.

我明白與此間診所註冊，也是註冊在 Pegasus Health 之下。我的名字和地址將被保存在此間診所，Pegasus Health 和国家註冊檔案

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

我明白我若去其他診所就醫，費用將會增加。

I have been given information about the benefits and implications of enrolment and the services this practice and PHO provides along with the PHO's name and contact details.

我已經被告知關於註冊的含義和所帶來的好處，此間診所能提供的服務，Pegasus Health 的名字和聯繫方式。

I have read and I 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.

我已閱讀並同意使用健康信息聲明。我在註冊表格上提供的資料將用於確定獲得公共資助服務的資格。信息可能與其他政府機構進行比較，但只有在“隱私法”允許的情況下

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

我的聯繫方式或是我的註冊資格若有改變，我會通知我所註冊的診所。

*Signatory Details 簽約細節			<input type="checkbox"/>	<input type="checkbox"/>
	Signature 我的簽名	Day / Month / Year 日期	Self Signing 我自己簽	Authority 權威人士帶 簽

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

如果因某種原因當事人無法認知註冊的意義也無法為自己的醫療方針做決定，權威人士法律上能帶簽

Authority Details 權威人士的資料 (where signatory is not the enrolling person)	Full Name 姓名	Relationship 與當事人的關係	Contact Phone 權威人士的電話
	Basis of authority (e.g. parent of a child under 16 years of age) 權威是基於：		