Health Improvement Group Enrolment Form 病人注册表

EDI Number botanymd

EAST HEALTH TRUST
primary health organisation

Select the practice you would like to enrol with 请选择您要注册的诊所:		
☐ **Botany Junction Medical** 110 Michael Jones Drive | 09 265 0321	☐ **Highbrook Medical** 31 Highbrook Drive | 09 273 4876	☐ **Ormiston Medical** 211 Ormiston Road | 09 265 1325

Legal Name 依法登记的名字	**Title:** 尊称	**Surname:** 姓	**First Name 名:** **Middle Name:**

NHI: (office use only)	**Date of birth 生日:**
Gender 性别: ☐ Male 男 ☐ Female 女 ☐ Gender Diverse 性别自我识知 *(please state 请注明)*	**Place of birth 出生地方:**
Occupation 职业:	**Country of birth 出生国家:**

Community Services Card 社区福利卡
☐ **Yes 是** / ☐ **No 否**
Card number 卡号:
Card Expiry Date 卡过期时间:

High User Health Card 高危病人卡
☐ **Yes 是** / ☐ **No 否**
Card number 卡号:
Card Expiry Date 卡过期时间:

Residential Address 住址	**Street Number 门排号:**	**Street Name 路名/街名:**	
	Suburb 区:	**City 城市:**	**Postcode 邮编:**
Postal address 邮寄地址	*if different to above 如果跟住址不一样*		

Home Phone 家庭电话:	**Work 工作电话:**	**Mobile 手机:**

Email 电子邮箱:		**Emergency Contact Name 紧急联系人:** **Relationship 关系:** **Tel. contact 电话:**
Do you agree to receive emails: 您是否同意收到电邮?	☐ **Yes 是** ☐ **No 否**	

Do you agree to receive text messages?您同意收到手机短信?	☐ **Yes** 是	☐ **No** 否	**Do you Smoke?** 您是否抽烟	☐ **Yes** 是	☐ **No (ex smoker)** 否,但曾经是 ☐ **Never** 否

Which ethnic group(s) do you belong to?
Tick the space or spaces which apply to you
您属于下列哪个民族人种?请打勾

- ○ New Zealand European 欧洲人
- ○ Maori 毛利人
- ○ Samoan 萨摩人
- ○ Cook Island Maori 库克群岛毛利人
- ○ Tongan 汤加人
- ○ Niuean 纽维人
- ○ Chinese 中国人
- ○ Indian 印度人
- ○ Other such as (Dutch, Japanese, Tokelauan) 其他
  Please state 请注明_____

Transfer of records
病历转移

In order to get the best care possible, I agree to this Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register.我同意此诊所从之前的家庭医生获得我的历史病历.我也明白,此后我将不再是前家庭医生的注册病人了.

☐ Yes 是 ☐ No 否 ☐ Not applicable 没有

Previous Doctor's name 前家庭医生的名字:
Address 前家庭医生的地址:

Phone 前家庭医生的电话:

Signature 签名_____

(agreement for transfer of records 同意病历转移)

Please turn over

My declaration of entitlement and eligibility 符合注册标准的声明

I am entitled to enrol because I am residing permanently in New Zealand *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 我符合注册的标准因为我是新西兰永久居民(打算在之后的 12 个月之内在新西兰居住至少 183 天)*	☐

I am eligible to enrol because 我符合注册的标准,因为:

A	I am a New Zealand citizen 我持有新西兰护照 *(If yes, tick box and proceed to **I confirm that, if requested, I can provide proof of my eligibility** below 如果是,打勾,并转到"我确认,如果有需要,我可以提供我符合注册标准的证明")*	☐

If you are **not a New Zealand Citizen**, please tick which eligibility criteria applies to you (B-J) below 如果您不持有新西兰护照,请在以下 B 到 J 打勾

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永久居民签证(或 2010 年 12 月份之前签发的居留许可)	☐
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.	☐
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(包含以前的工作许可).	☐
E	I am an interim visa holder who was eligible immediately before my interim visa started 我持有临时签证,在得到临时签证之前我是符合注册标准的.	☐
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 我是一个难民或者受保护,或者在申请的过程中,或者正在上诉难民或受保护申请,或者是受害人或被怀疑是人口贩卖的受害人,	☐
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 **OR** in the control of the Chief Executive of the Ministry of Social Development 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	☐
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 岁并且父/母是一个新西兰援助计划的学生)	☐
I	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme 我参加教育部外国语助教奖学金计划	☐
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 我持有英联邦奖学金在新西兰学习,并且从新西兰大学获得英联邦奖学金	☐

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	☐
we will retain a copy for eligibility purposes only — Evidence Sighted (office use only)	☐

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 intend to use this practice** as my regular and ongoing provider of general practice/GP/health care services.
我计划用这个诊所为我提供主要的医疗服务

→ **I understand** that by enrolling with this practice I will be included in the enrolled population of East Health Trust Primary Health Organisation, and my name, address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers.
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,地址以及其他身份证明将被保留在此诊所和此机构.

→ **I understand** that if I visit another health care provider where I am not enrolled I may be charged a higher fee.
我明白如果我去除此诊所以外的其它诊所,我可能会被要求付更高的诊金.

→ **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 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. **我已阅读并同意关于使用健康信息的声明.我注册时提供的信息会被用来确认我使用公立服务的资格.在隐私法允许的情况下,我提供的信息可能会用来和其他政府部门的信息对比.**

→ **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.**我明白诊所会参与关于人们的医疗保健经验的全国调查,以及他们如何管理他们的健康护理. 参加调查是自愿的,所有回复将是匿名的.我可以拒绝参与调查,或通知诊所退出调查.调查提供了用于提高改善卫生服务的重要信息.**

→ **I agree** to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.
我同意如果我的联系方式或注册资格有变动,我回通知诊所.

Signatory Details 签名	Signature 签名_____	Date 日期 __/___/____	☐ Self-Signing 本人	☐ Authority 监护人

***An authority** has the legal right to sign for another person if for some reason they are unable to consent on their own behalf*
授权是代替另一个人合法签名,如果对方因为某种原因无法自己签名.

Authority Details 监护人 *(where signatory is not the enrolling person)*	**Full Name:** **监护人姓名**	**Relationship:** **关系**
	Contact Phone: **监护人电话**	**Basis of authority 授权原因:** *(e.g. parent of a child under 16 years of age 比如:未满 16 岁患儿的父母)*