HONG KONG SURGERY ENROLMENT FORM

GP2GP: First name – HONGSHENG Surname – KONG
NZMC - 27221 EDI – hongkong
P.O. Box 14493, Panmure, AKL 1741 www.mygp.co.nz
Phone: 09 527 8829 E-mail: hks5278829@live.com

				NHI*病案号	
Title 称呼		First*Name(s)名		Family Name*姓	
Preferred Name 惯用名				Occupation/职业	
Gender*性别	☐ Male 男 ☐ Female 女 ☐ Gender Diverse (please state)			Place and Country of birth*出生城市和国家	
Physical Address* 住址	Street number 门牌号	Name of Street 街道名		Date of Birth* 出生日期	_____/_____/_____ Day 日 Month 月 Year 年
	Suburb 地区			High User Card 高用户卡	YES 有 / NO 没有
	City/Town 城市	Postcode 邮政编码		Card Number: 卡号	
Postal Address 通信地址				Community Services Card 社区服务卡 Card Number 卡号	YES 有 / NO 没有
Contact Details	Day Phone 上班电话	Night Phone 住宅电话	Cell Phone 手机 Consent to text/email communications	Email 电子信箱	
Emergency contact 紧急联络人	Name of person to contact 联系人姓名	Relationship 关系	Phone number 电话号码 Consent to text communications	Other contact details 其他联系方式	

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 laminated sheet)* 注册资格*(见塑胶页)** I confirm that, if requested, I can provide proof of my eligibility 我保证，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. ☐
☐ 11 New Zealand European	☐ Current 吸烟者	☐ Not Eligible 没有资格
☐ 21 Māori Iwi:	☐ Ex-Smoker 戒烟者	*Eligible under criteria 符合资格的条件 (enter applicable letter from laminated sheet （请从塑胶页列表选择合适的字母) *
☐ 31 Samoan		
☐ 32 Cook Islands Maori	☐ Never Smoked 从不吸烟	I have read and agree with the Health Information Privacy Statement, and Patient Experience Survey.我已阅读并同意"健康资料隐私权声明和参与病人体验调查". (tick 请打勾) *
☐ 33 Tongan		
☐ 34 Niuean	Transfer of Records 移交医疗记录 ☐Yes 是 ☐No 不要	
☐ 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 为了得到最好的照顾，我同意从我以前的医生处移交我的记录。我明白，我会从他们诊所的注册名单中被删除.	
☐ 42 Chinese 中国人		
☐ 43 Indian	Doctor's Name 医生的姓名:_____	
☐ 54 Other such as DUTCH, JAPANESE Please state:	Address / Location 诊所地址: _____	

SIGNATURE 签名* **DATE 日期 day /mth /year**

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 联系电话号码:	Relationship **亲属关系:**
Address 住址:	Signature of Authority 授权人签名:	/ / Day Month Year

I am entitled to enrol because I intend to be resident in NZ for at least 183 days in the next 12months. ☐
我有权利注册因为我打算在以后的 12 个月里至少 183 天居住在新西兰 ☐

See laminated info sheet - for Eligibility and Health Information privacy statement 请参阅塑胶页信息表 - 资格和健康资讯隐私声明