CARING CLINIC DOCTORS ENROLMENT FORM

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				*NHI 医疗号	
Title 称呼		***First Name(s)名**		***Family Name 姓**	
Preferred Name 惯用名				***Date of Birth 出生日期**	____/____/______ Day 日 Month 月 Year 年
***Gender 性别**	☐ Male 男 ☐ Female 女 ☐ Gender Diverse (please state) 其他			***Place & Country of birth 出生城市、国家**	
***Physical Address 住址**	Street number 门牌号	Name of Street 街道名		**Occupation/职业**	
	Suburb 地区			***High User Card 高危病人卡**	**YES 有 / NO 没有**
	City/Town 城市	Postcode 邮政编码		**Card Number & Expery Date 卡号及过期日**	
Postal Address 通信地址	☐ tick if same as above 同上请打勾			**Community Services Card 社区服务卡**	**YES 有 / NO 没有**
				Card Number 卡号	
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) ☐同意接收短信请打勾	***Email 电子邮箱** (Tick box to accept emails) ☐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	
☐ 11 New Zealand European	☐ 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)	*
☐ 21 Māori Iwi:	☐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).	*
☐ 31 Samoan			
☐ 32 Cook Islands Maori	☐ Never Smoked 从不吸烟	☐ **Not Eligible 没有资格** (Tick if not eligible under any criteria over page 请打勾)	
☐ 33 Tongan			
☐ 34 Niuean	***Transfer of Records 移交医疗记录** ☐Yes 是 ☐No 否 ☐Not applicable 没有		
☐ 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。		
☐ 42 Chinese 华人	**Doctor's Name 前家庭医生的姓名：**		
☐ 43 Indian	**Address / Location 前家庭医生的诊所地址：**		
☐ 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