# HONG KONG SURGERY ENROLMENT FORM

GP2GP: First name – HONGSHENG Surname – KONG
NZMC - 27221 EDI – hongkong
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| | | | |
|---|---|---|---|
| | | 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 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***

- ☐ 11 New Zealand European
- ☐ 21 Māori Iwi:
- ☐ 31 Samoan
- ☐ 32 Cook Islands Maori
- ☐ 33 Tongan
- ☐ 34 Niuean
- ☐ 35 Tokelauan
- ☐ 42 Chinese 中国人
- ☐ 43 Indian
- ☐ 54 Other such as DUTCH, JAPANESE
  Please state:

**Smoking Status 吸烟状况**

- ☐ Current 吸烟者
- ☐ Ex-Smoker 戒烟者
- ☐ Never Smoked 从不吸烟

**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.

☐ Not Eligible 没有资格

***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)

**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) *

**Transfer of Records 移交医疗记录** ☐Yes 是 ☐No 不要

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.

**Doctor's Name 医生的姓名:**_____

**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