

 	ENROLMENT FORM 注册表	 DW Family Doctors 1-123 Pakuranga Road Pakuranga, Auckland 2010 Email: infodwdoctors@gmail.com Contact Phone Number: 09-5765177
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Fields marked with an * are compulsory	EDI/GP2GP: dwdoctor GP2GP: Dr David Wu NZMC: 37695	Chart no (Office use only) *NHI (Office use only)
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Name (名字)	(Title) (称呼)	*Given Name (名)	*Other Given Name(s) 其他名字	*Family Name (姓)
Birth Details 生日		*Day / Month / Year of Birth (日/月/年)	*Place of Birth (出生地)	*Country of birth (出生国家)
Gender 性别	☐ *Male 男	☐ *Female 女	☐ *Gender diverse (please state)	

Usual Residential Address 常用地址	*House (or RAPID) Number and Street Name		*Suburb/Rural Location	*Town / City and Postcode
Postal Address (if different from above) 邮寄地址 (如果和以上不同)	House Number and Street Name or PO Box Number		Suburb/Rural Delivery	Town / City and Postcode

Contact Details 联系方式	Mobile Phone (手机)	Home Phone (座机)	Email Address (电邮)
Do you consent to the practice sending TEXT messages for the purpose of recalls, surveys & updating your details? 您是否同意本诊所通过短信 (TEXT) 与您联系, 用于随访提醒、问卷调查以及更新您的个人信息?			☐ 是 Yes ☐ 不 No
Do you consent to the practice sending EMAILS for the purpose of recalls, surveys & updating your details? 您是否同意本诊所通过电子邮件与您联系, 用于随访提醒、问卷调查以及更新您的个人信息?			☐ 是 Yes ☐ 不 No
Emergency Contact 紧急联络人	Name (名字)	Relationship (关系)	Mobile (or other) Phone (手机或座机)

Privacy Statement (Summary) We collect and use your health information to provide care, manage your enrolment, and support health system requirements. This includes information you provide to us, as well as information we receive from other health providers and authorised organisations involved in your care. We may also receive and update your information through national health systems, including the National Health Index (NHI) and enrolment systems, to ensure your details are accurate. Further information is available in our Health Information Privacy Statement. 隐私声明 (摘要) 我们会收集和使用您的健康信息, 用于提供医疗服务及管理您的注册。这些信息包括您提供的资料, 以及来自其他参与您医疗服务的医疗机构或授权组织的信息。我们也可能通过国家健康系统 (如 NHI) 更新您的资料, 以确保信息准确。更多详情请参阅《健康信息隐私声明》
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Transfer of Records I agree to DW Family Doctors obtaining my records from my previous doctor, which will mean I will be removed from their practice register. Relevant information may also be received from other health providers involved in my care. 病历转移 我同意 DW Family Doctors 从我之前的医生处获取病历, 并理解这将使我从原诊所注册中移除; 同时同意从其他参与我医疗服务的机构获取相关信息	
☐ Yes, please request transfer 同意	☐ Not applicable
Previous Doctor and/or Practice Name and Address 前任家医或者诊所名字及地址	
Signature 签名	
Date 日期	

Occupation 职业	Company Name 公司名字	Occupation 职业
	Company Address 公司地址	Work Phone 工作电话

*Ethnicity Details Which ethnic group(s) do you belong to? Tick the space or spaces which apply to you	☐ New Zealand European ☐ Maori ☐ Samoan ☐ Cook Island Maori ☐ Tongan ☐ Niuean ☐ Chinese 中国 ☐ Indian ☐ Other 其他族裔 (such as Dutch, Japanese, Tokelauan). Please state 	Iwi:	
		Hapu:	
种族 请在右侧选择并打勾		Community Services Card Number 社区服务卡号	Expiry Date 有效期
		High User Health Card Number 健康卡	Expiry Date 有效期
		Smoking status (if over 15) 吸烟状态查询 (15 岁以上) ☐ Never smoked 从不吸烟 ☐ Ex-smoker 曾经吸烟 - ☐ Greater than 15months 烟龄超过 15 年 ☐ less than 12 months 烟龄小于 12 个月 ☐ Current smoker 当前吸烟者	
		If you are a current smoker or have recently quit, we would like to help you stop to improve your health. Would you like help to stop to quit/stay an ex-smoker? 如果您目前吸烟或最近刚戒烟, 我们希望协助您戒烟以改善健康。您是否希望获得帮助戒烟或保持戒烟状态? ☐ 是的 Yes ☐ 不需要 No	

My declaration of entitlement and eligibility

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>		☐
I am eligible to enrol because:		
a	I am a New Zealand citizen (If yes, tick box and proceed to I confirm that I can provide proof of my eligibility below)	☐
If you are not a New Zealand citizen, please tick which eligibility 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)	☐
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	☐
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)	☐
e	I am an interim visa holder who was eligible immediately before my interim visa started	☐
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	☐
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	☐
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)	☐
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	☐
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	☐

I confirm that I can provide proof of my eligibility 我确认 我可以提供符合注册资格的证明	☐	Evidence sighted (Office use only)
My work/student/visitor/other visa is valid for a period of 工作/学生/旅游访问/其他等签证有效期	Year(s):	Expiry Date:

My agreement to the enrolment process

NB. Parent or Caregiver to sign if you are under 16 years

16 岁以下必须由父母和监护人代签

I intend to use this practice as my regular and on-going provider of general practice / GP / health care services.

I understand that by enrolling with the **DW Family Doctors** I will be included in the enrolled population of National Hauora Coalition PHO, and my name address and other identification details will be included on the Practice, PHO, and National Enrolment Service Registers.

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

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.

I have read and I agree with the Health Information Privacy 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.

I understand that information about me may also be obtained from other health providers and health information systems to support my care and maintain accurate enrolment records.

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.

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

Signatory Details (16 岁以上)	Signature 签名	Day / Month / Year 日/月/年	☐ Self Signing 本人签	☐ Authority 授权代签
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An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Authority Details (Where signatory is not the enrolling person) 授权人信息	Full Name 姓名	Relationship 关系	Contact Phone 联系电话
Basis of authority (e.g. parent of a child under 16 years of age) (授权理由) (比如: 16 岁以下小孩的父母或监护人)			

Primary Health Services Provider Enrolment Form Last Updated May 2026

Office USE ONLY

ENTERED	SCANNED	EMAILED
CHECKED	NHI Registration	Review date