New Patient Registration Form - Village Surgery

Please find attached Village Surgery Registration pack, all forms MUST be completed in full and returned to us in person with the required identification. Please bring a copy of your previous vaccinations, to be added to your patient record.

Identification - Reception will take a photo copy of the relevant identification

Pack Contents

*New Patient Registration Form / GMS1 Form / Sharing Consent Form / NHS Care Summary Record Information / Practice Leaflet*

|  |
| --- |
| Title:............Name:...........................................................................DOB:.....................................  Address:......................................................................................................................................  Postcode:...................................... Email Address:..............................................................(Print)  Mobile:......................................................................Landline:.....................................................  SMS consent - Yes No |

Communication Needs - Please advise a member of the reception team if you have any communication requirements you need assistance with, alternatively advice below -

|  |
| --- |
|  |

Next of Kin

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mothers Details- If not as above

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fathers Details- If not as above

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity / Language

Ethnic Origin:.......................................................Main Spoken Language:...........................................

English Speaker – ***Please tick*** YES NO

If Applicable – Country born in - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date arrived in UK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Pharmacy Nomination  As of 1st November 2019 all prescriptions will go electronically to your nominated local pharmacy, please give details of this:  Nominated Pharmacy:  Alcohol Consumption  Number of Units per week\_\_\_\_\_\_\_\_  (small glass wine = 1 unit, 1 pint of beer = 2 units, 1 pub measure of spirit = 1 unit)   |  | | --- | |  |   Allergies  Any drug allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any other allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Smoking Status – *Please Tick*

Are you a smoker? Yes No Have you ever smoked? Yes No

Approx date stopped - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History – Have any of your blood relatives suffered from the following?

Heart Attack Cancer Diabetes High Blood Pressure Asthma Stroke Angina

Current on-going issues – Do you currently suffer from any of the following long term illnesses (Please tick)

Asthma  Diabetes  High Blood Pressure 

Cancer  COPD 

Other (Please Specify) ……………………………….……………………………….………………………………………….

Summary Care Record – *Please sign*

*Please read the attached NHS Summary Care Record*

Do you want a summary care record? Yes No Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Carer Information- Please sign the following section and give consent that medical information can be shared with this person.

Carer Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Online Access  Village Surgery provides its patients with the ability to use online access. If you have provided the practice with a valid email address for online access you can –  **Book appointments online / Request medication / View summary record**  If you would like access to online please sign below, your identification will be checked during registration, you will receive an email at a later stage with your username and password.  Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Online access is only accessible for patients aged 16 +.  Reception use only  Identification checked: ................................................Date:........................................ |

**Proof of Identity – For Reception Staff to complete**

Under NHS counter-fraud measures, we are required to ask for your proof of identity. Type- *(please tick)*

Passport Driving Licence Birth Certificate Utility Bill

Bank Statement Rent Card Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copy Taken - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide at least one item of identification from list A and one item from List B. One of these documents **MUST** show your current address that you are using to register at Village Surgery.

List A

Passport, Driving Licence, Home Office Papers, NHS Medical Card, National Insurance Number Card, Birth Certificate.

List B

Marriage Certificate, Local Authority Rent Card, Paid Utility Bill (under 3 months old), Benefits Agency Letter/Benefit Book/Signing On Card, Current Payslip or P45.

**(Note: The following are NOT acceptable as proof of identity – library card, health club membership card, private rent book, loyalty cards, membership cards, credit and debit cards.)**