Registration Form.

Ballasalla Group Practice

Patients 16yrs and Over will need to bring Photo Id and proof of address when registering.

First name*	Patient Details – Please complete all relevant sections in BLOCK CAPITALS and tick where appropriate Your registration will not be processed unless all fields marked * are completed	
Date of Birth* / / Preferred name (if different from first name) NHS No. (if known) *Male Female Other *Male Female Other *Male Female Other Post Code* Mome address*	Title* Surname*	
Preferred name (if different from first name) NHS No. (if known) *Male Female Other *Male Female Other Mobile phone No. Post Code* Post Code* Home Telephone No Can we contact you by text if required? Yes No Do you support a relative, friend, or neighbour free of charge who needs help with their daily living? Yes No Do you support a relative, friend, or neighbour free of charge who needs help with their daily living? Yes No Do you have a carer to support you with your daily living? Yes No Do you have a carer to support you with your daily living? Yes No Postcode To help us trace your medical records please provide the following information: Your Previous Address* Name & address of your Doctor while at that address* Postcode Town of Birth* Country of Birth* Country of Birth* Town of Birth* Country of Birth* Town of Birth a GP Date you first came to live in the UK, the date you left to live abroad	First name* Middle name	e (s)
Male Female Other Home address Post Code* Post Code* Home Telephone No Can we contact you by text if required? Yes No Email address Can we contact you by email if required? Yes No Do you support a relative, friend, or neighbour free of charge who needs help with their daily living? Yes No Do you support a relative, friend, or neighbour free of charge who needs help with their daily living? Yes No Do you support a relative, friend, or neighbour free of charge who needs help with their daily living? Yes No Do you have a carer to support you with your daily living? Yes No To help us trace your medical records please provide the following information: Your Previous Address* Name & address of your Doctor while at that address* Postcode Town of Birth* Country of Birth* Country of Birth* Country of Birth* Town of Birth* Town of Birth a GP Date you first came to live in the UK/IOM If previously resident in the UK, the date you left to live abroad	Date of Birth* / Any previous surname([s]
Home address*	Preferred name (if different from first name)	NHS No. (if known)
Post Code* Home Telephone No Mobile phone No. Can we contact you by text if required? Yes Mobile phone No. Can we contact you by email if required? Yes Email address Can we contact you by email if required? Yes Do you support a relative, friend, or neighbour free of charge who needs help with their daily living? Yes No Do you have a carer to support you with your daily living? Yes No To help us trace your medical records please provide the following information: No Your Previous Address* Name & address of your Doctor while at that address* Postcode Image: Solution of Birth* Country of Birth* Country of Birth* If you are from abroad: Pate you first came to live in the UK/IOM If previously resident in the UK, the date you left to live abroad If previously resident in the UK, the date you left to live	*Male Female Other	
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abroad		Date you first came to live in the UK/IOM
abroad		If previously resident in the UK, the date you left to live
	Postcode	

For children 12 and under we need consent to advise the community health visitor that they have joined the practice. Please tick to indicate your consent

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Next of Kin Details – if completing the registration for a child under 16, provide details of those with parental responsibility		
Full Name	Full Name	
Contact No.	Contact No.	
Relationship to patient	Relationship to patient	
Consent to EMIS Web Shared Record Access EMIS Web is	the computer system used by the Practice. Shared record	

Consent to EMIS Web Shared Record Access EMIS Web is the computer system used by the Practice. Shared record consent means that you are giving other health care professionals permission to view your medical record. This could be important if you need urgent medical care when the surgery is closed (for example MEDS or A&E). You can change your mind about this choice at any time by informing the receptionist. What information is shared: This will include information like test results, medication, allergies and basic demographics (name, address, date of birth etc.) Your information is held securely in compliance wih GDPR and LED implementing regulations 2018 and will only be shared with the staff members directly involved in your care delivery. Do you give consent for your record to be shared? Yes No

Due to GDPR legislation we need written consent if you wish another person to collect prescriptions or other documents from the surgery on your behalf, or to make or cancel appointments for you. We also need written consent if you wish someone else to be able to discuss your medical record with the GP. Forms for this are available at reception or on the website if required.

I declare that to the best of my knowledge the information contained in this form is true and accurate.

DATE_

Your registration will not be processed unless all fields marked * are completed

OFFICE USE ONLY – TO BE COMPLETED BY PRACTICE STAFF:		
Photo ID: ID Checked 🗌 DOB Checked 🗌		
Passport 🗌 Driving License 📄 Bus Pass 🗌 Student ID Card 🗌		
Other (specify) Valid until:		
Proof of address seen		
Received: date:		