Registration Form.

Ballasalla Group Practice

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

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

Title*_____ Surname*_____

First name* _____ Middle name (s) _____

Date of Birth* ____ / ____ / _____ Any previous surname(s) _____

Preferred name (if different from first name) _____ NHS No. (if known) _____

*Male ☐ Female ☐ Other ☐ _____

Home address* _____

_____

_____

Post Code* _____ Home Telephone No _____

Mobile phone 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 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***
If you are from abroad:		
Your first UK address where you registered with 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
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 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.

SIGNED _____ **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: …… Initials: …….