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**NEW PATIENT REGISTRATION FORM**

**ONCE ALL SECTIONS OF THIS QUESTIONNAIRE ARE COMPLETED AND RETURNED YOUR REGISTRATION WILL BE PROCESSED**

Please write in **BLACK INK AND BLOCK CAPITALS.**

The information that you provide will be treated in the strictest confidence.

**If you are completing this form for a person who is under 16 years of age, please provide YOUR photo ID AND a copy of the child’s birth certificate or red book**.

**Upon return of this form, we will need to see each person over 16 individually, with 2 forms of identification each (photo ID and proof of address)**

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| **PERSONAL DETAILS** |
| **Title** |  | **First Name &****middle name**  |  | **Surname** |  |
| **Previous Name** |  | **Address** |  |
| **Preferred Name** |  |
| **Date of Birth** |  |
| **NHS Number** |  | **Postcode** |  |  |
| **Home Tel No** |  | **Email** |  |
| **Mobile Tel No** |  | **Sex** | Male Female  |
| **Work Tel No** |  | **Country of Birth** |  |
| **Town of Birth** |  | **Occupation** |  |

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| **EMERGENCY CONTACT DETAILS**This will be the person that the surgery contacts in case of Emergency |
| **Title** | Mr/DrOth | Mrs/Ms/Miss/er: | **First Name** |  | **Surname** |  |
| **Home Tel No** |  |  |  |  |  |  |
| **Mobile Tel No** |  |  |  |  |  |  |
| **Work Tel No** |  |  |  |  |  |  |
| **Relationship to you** |  |  |  |  |  |
| **Is this person also your Next of Kin?** | Yes No  |
| **Can this person discuss your medical records?**This person will have access to your appointments, results and other confidential information.You will contact the Practice if any of these details change. | Yes No  |
| **Signature:** | **Date:** |

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| **CARER DETAILS**(You are a carer if you spend a significant portion of your time providing paid/unpaid support to another person) |
| Are you a carer? (If “Yes” please tell us who for (Name) and their relationship to you) | Yes |  | No |  |

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| **Previous Home****Address** |  |
| **Previous GP** |  |

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| **Repeat Medications**  |
| **If you take regular medication prescribed by your previous surgery please make an appointment to see a GP who will review these with you and add them onto your record here.**  |
| If you wish to have your **prescriptions sent electronically to a Pharmacy** of your choice please add the name and address of this chemist. |

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| **If you are from ABROAD** |
| **First UK address where registered with GP** |  |
| **If previously resident in the UK, date of leaving** |  |
| **Date you first came to live in the UK** |  |

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| **ARMED FORCES** |
| **Are you a military veteran?** | Yes No  |
| **If you are currently RETURNING from the ARMED FORCES please answer the following questions:** |
| **Service or Personnel Number** |  |
| **Enlistment Date** |  |

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| **NHS ORGAN DONOR REGISTRATION** |
| I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death.*Please tick as appropriate:** Any of my Organs and Tissue

**OR**  Kidneys  Heart  Liver  Corneas  Lungs  Pancreas*For more information visit:* [*www.uktransplant.org.uk*](http://www.uktransplant.org.uk/) *or call (0300) 123 23 23****Please sign and date to confirm consent:*** |
| **Signature** |  | **Date** |  |

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| **NHS BLOOD DONOR REGISTRATION** |
| **PLEASE READ BEFORE SIGNING:**If you are **aged 66-70**, you can only donate blood if you have donated previously.If you are **aged over 70**, you can only donate blood if you have donated in the last 2 years |
| I would like to, and am eligible to, join the NHS Blood Donor Register as someone who may be contacted, and would be prepared to donate blood.Tick if you have given blood in the last 3 years *For more information ask for the leaflet on joining the NHS Blood Donor Register****Please sign and date to confirm that you are eligible to donate, and to give your consent:*** |
| **Signature** |  | **Date** |  |

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| **SMOKING STATUS****(Over 16 yrs only)** |
| Do you smoke? |  |
| **Yes**  How many cigarettes a day?  | **No**  - Have you ever smoked? Yes No  |
| Would you like help to stop smoking?**Yes**  No  | If Yes, please give the **date you stopped**: |
| If **Yes**: Support will be provided by Nottingham Community Health NHS Trust Stop Smoking Services, who will be in contact with you shortly. We are required to send them some basic information from your record, e.g. name, address, DOBI consent to the practice sharing my details as above (Signature)\* The Stop Smoking Service can leave a message for me (Signature)\***\* Please ensure you have included your mobile telephone number and/or email address on this form.** |

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| **ALCOHOL CONSUMPTION****(Over 18 yrs only)** |
| Alcohol can affect your health and certain medications.Use the guide below to assess how many units you drink in a week. |
| Do you drink alcohol? | Yes - Units per week: No  |
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| Past & Present Medical Conditions | Y/N | more info & date when diagnosed/resolved |
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| **Arthritis** (XM1RU) (SNOMED: 275554004) |  |  |
| **Asthma** (14B4.) (SNOMED: 161527007) |  |  |
| **Autoimmune endocrine disease** (XaXTx) (SNOMED: 472968007) |  |  |
| **Cardiovascular disease** (XE0q8) (SNOMED: 266995000) |  |  |
| **CVA (stroke)** (XM1R2) (SNOMED: 275526006) |  |  |
| **Dementia** (1461.) (SNOMED: 161465002) |  |  |
| **Depression** (1465.) (SNOMED: 161469008) |  |  |
| **Diabetes mellitus** (1434.) (SNOMED: 161445009) |  |  |
| **Epilepsy** (1473.) (SNOMED: 161480008) |  |  |
| **Heart failure** (14A6.) (SNOMED: 161505003) |  |  |
| **Hypertension** (14A2.) (SNOMED: 161501007) |  |  |
| **Heart disease** NOS (14AA.) (SNOMED: 275544003) |  |  |
| **Kidney disease** (XM1RS) (SNOMED: 275552000) |  |  |
| **Liver disease** (14C5.) (SNOMED: 161535005) |  |  |
| **Peptic ulcer** (XE0qB) (SNOMED: 266998003) |  |  |
| **Thyroid disorder** (XM1RC) (SNOMED: 275536003) |  |  |
| **Stroke** (XM1R3) (SNOMED: 275526006) |  |  |
| **Neoplasm** (XM1XX) (SNOMED: 275904003) |  |  |

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| **Do you have an adverse reaction to any medication?** | **If Yes, please list here:** |

 **Patient Access – Online Services**

We offer online access for you to book/cancel appointments, view some of your medical information and order repeat medication.

You need to be registered for this service in order to use it.

You can *only* apply for yourself and must be aged 16 or over. Photo ID is required to register for this service.

**Patient Access – Online Services continued…**

**I wish to access my medical record online and understand and agree with each statement (tick)**

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| 1. I will be responsible for the security of the information that I see or download
 |  |
| 1. If I choose to share my information with anyone else it is at my own risk
 |  |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement.
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| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.
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| **Signature :**  | **Date:** |

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| **I wish to have access to the following online services**  | Tick |
| 1. Booking appointments
 |  |
| 1. Requesting Repeat Prescriptions
 |  |
| 1. Accessing my medical records.
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# Data Sharing

## We take the confidentiality of your personal and medical information very seriously.

When appropriate, Bramcote Surgery will share pertinent details of your clinical record between the various care professionals who are or will be involved in your clinical care (your GP, local hospitals, district nurses, out of hours services, health visitors, etc). This data is only used for your direct medical care.

There are other occasions when we have requests to share your data. You have the option to OPT OUT of these. On the next pages these options are explained and you must sign each section if you wish to opt out.

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| **COMMUNICATION PREFERENCE** (AIS)If you require additional assistance when communicating with the practice, please indicate it below by ticking the relevant box. If not, please tick ‘No additional assistance required’ |
| No additional assistance required, thank you. |
| **SIGHT** | **SOUND** |
| Large Print |  | British Sign Language |  |
| Braille (state grade) |  | Audio Cassette Tape |  |
| Other (please state) |  | Other (please state) |  |

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**SUMMARY CARE RECORD (SCR)**

 **Please only sign if you wish NOT to share your record with hospitals etc**

NHS England has introduced the Summary Care Record, which will be used in emergency care.

The record will only contain information about any medicines you are taking, allergies from which you suffer and any adverse reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare professionals providing your care anywhere in England, but they will, where possible, ask your permission before they look at it. This means that if you have an accident or become ill, those treating you can have immediate access to important information about your health.

***If you do not sign a section you are automatically opted IN for that service.***



**SMS (Text) Messaging Service**

We may use SMS messaging to communicate with patients who have provided us with a mobile number, for the purposes of health education/promotion, data collection for research, test results and reminders.

Information sent via an SMS message will be generic and no information which identifies an individual patient such as name, address, or other items of personal detail will be included. Information stating the reason for the message will be kept to a minimum.

Where an important matter is to be conveyed to the patient a letter or other reliable method will be used.

IF YOU **DO NOT CONSENT** TO TEXT MESSAGES SIGN BELOW

**Email Services**

We may use email messaging to communicate with patients who have provided us with an email address, for the purposes of health education/promotion, data collection for research, test results, reminders and other medical information.

If you are expecting correspondence via this method, which you haven’t received, please check your spam folder.

Please add your email address: …………………………………………………………………………….

Signature for consent …………………………………………………………………………………………

Date………………………………………………………

**Join Our PPG**

If you are interested in joining the Bramcote Surgery **P**atient **P**articipation **G**roup

This practice has an active Patient Participation Group representing patients’ interests and strengthening the relationship between the practice and its patients. If you would like to be kept informed by receiving a copy of the minutes or joining the group (when there is a vacancy) please include your email and sign to agree to the practice sharing this information with the PPG Chairperson.

*(Please note that the PPG* ***does not*** *have any access to any patient related notes or information and have all signed a confidentiality agreement as part of their membership)*

I would like to be emailed information from the Bramcote Surgery PPG

Signature……………………………………………………………………………….. ………………………………………………………….Date……………………….

**GMS1 SUPPLEMENTARY QUESTIONS**

**Please only fill in if you are NEW to the UK**

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| **PERSONAL DETAILS** |  |
| **Title** | Mr/Mrs/Ms/Miss |
| **Forenames** |  |
| **Surname** |  |
| **Date of Birth** |  |

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| **PATIENT DECLARATION for all patients who are not ordinarily resident in the UK** |
| Anybody in England can register with a GP practice and receive free medical care from that practice.However, if you are not ‘ordinarily resident’ in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of ‘indefinite leave to remain’ in the UK.Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.**You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.****The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.****Please tick one of the following boxes:**1.  I understand that I may need to pay for NHS treatment outside of the GP practice
2.  I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge (“the Surcharge”), when accompanied by a valid visa. I can provide documents to support this when requested
3.  I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.**A parent/guardian should complete the form on behalf of a child under 16.** |
| **Signed:** |  | **Date:** | **DD MM YY** |
| **Print name:** |  | **Relationship to patient:** |  |
| **On behalf of:** |  |

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| **Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but****work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.** |
| **NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS** |
| Do you have a non-UK EHIC or PRC? | YES:  NO:  | If YES, please enter details from your EHIC or PRC below: |
| *If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC)/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.* | Country Code : |  |
| 3: Name |  |
| 4: Given Names |  |
| 5: Date of Birth | **DD MM YYYY** |
| 6: Personal IdentificationNumber |  |
| 7: Identification numberof the institution |  |
| 8: Identification number of the card |  |
| 9: Expiry date | **DD MM YYYY** |
| PRC validity period (a) From: | **DD MM YYYY** | (b) To: | **DD MM YYYY** |
| Please tick  if you have an S1 (eg. you are retiring to the UK or you have been posted here by your employer for work or you livein the UK but work in another EEA member state). **Please give your S1 form to the practice staff**. |
| **How will your EHIC/PRC/S1 data be used?** By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country. |