

Patient's details

Please complete in BLOCK CAPITALS and tick as appropriate

Mr Mrs Miss Ms Surname _____
 Date of birth _____ First names _____
 NHS No. _____ Previous surname/s _____
 Male Female Town and country of birth _____
 Home address _____
 Postcode _____ Telephone number _____

Please help us trace your previous medical records by providing the following information

Your previous address in UK _____ Name of previous GP practice while at that address _____
 Address of previous GP practice _____

If you are from abroad

Your first UK address where registered with a GP _____
 If previously resident in UK, date of leaving _____ Date you first came to live in UK _____

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: Regular Reservist Veteran Family Member (Spouse, Civil Partner, Service Child)
 Address before enlisting: _____
 Postcode _____

Service or Personnel number: _____ Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)
 Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

I live more than 1.6km in a straight line from the nearest chemist
 I would have serious difficulty in getting them from a chemist
 Signature of Patient Signature on behalf of patient

*Not all doctors are authorised to dispense medicines

Date ____/____/____

What is your ethnic group?

Please tick one box that best describes your ethnic group or background from the options below:

White: British Irish Irish Traveller Traveller Gypsy/Romany Polish
 Any other white background (please write in): _____
Mixed: White and Black Caribbean White and Black African White and Asian
 Any other Mixed background (please write in): _____
Asian or Asian British: Indian Pakistani Bangladeshi
 Any other Asian background (please write in): _____
Black or Black British: Caribbean African Somali Nigerian
 Any other Black background (please write in): _____
Other ethnic group: Chinese Filipino
 Any other ethnic group (please write in): _____
Not stated:

Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

NHS England use only Patient registered for GMS Dispensing

To be completed by the GP Practice

Practice Name _____

Practice Code _____

 I have accepted this patient for general medical services on behalf of the practice

 I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Practice Stamp

Authorised Signature

Name _____

Date ____/____/____

SUPPLEMENTARY QUESTIONS – These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

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:

- a) I understand that I may need to pay for NHS treatment outside of the GP practice
- b) 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
- c) 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:			

Complete this section if you live in an EU 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: <input type="checkbox"/> NO: <input type="checkbox"/>	If yes, please enter details from your EHIC or PRC below:
 <p><i>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.</i></p>	Country Code: <input type="text"/>	
	3: Name	<input type="text"/>
	4: Given Names	<input type="text"/>
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	<input type="text"/>
	7: Identification number of the institution	<input type="text"/>
	8: Identification number of the card	<input type="text"/>
	9: Expiry Date	DD MM YYYY
	PRC validity period (a) From:	DD MM YYYY

Please tick if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in 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 Business Service Authority for the purpose of recovering your NHS costs from your home country.

**FIRST HEALTH UK LIMITED
St John's Surgery**

Welcome to St John's Surgery

New patient questionnaire guidelines:

Please complete all areas on the form where possible.

Appointments:

Please ensure that this registration is completed 48 hours before an appointment is required.

Identification:

Passport, Photo Driving Licence or Birth Certificate will be required before registration can be completed.

Your NHS number can be obtained from your previous GP surgery.

Medication:

If you are on any repeat medication please enclose a list such as your repeat slip so this can be processed ready for your next request and clearly mark if you require any items at the time – please allow 7 days for your order after registering.

Next of Kin:

Please provide name, address and telephone number and relationship details.

Family History and Chronic Illnesses/Operations:

Please provide any immediate family history and any current or past history for yourself.

New Patient Appointment:

We offer a New Patient appointment with one of our Nurses – which should be booked when handing in your completed registration forms.

Thank you for your time, if you have any queries with regards to these forms please do not hesitate to ask a member of our reception team.

OFFICE USE ONLY:

Date Checked / Reception To Sign

_____ / _____

TERRINGTON ST JOHN SURGERY
First Health UK Limited
NEW PATIENT QUESTIONNAIRE

Office u
only

NAME: _____ D.O.B: _____ GENDER: M/F

ADDRESS: _____ HOME TELEPHONE NUMBER: _____

MOBILE NUMBER: _____

PREFERRED TELEPHONE
NUMBER: _____

REASON FOR REGISTRATION:

MOVED INTO AREA
MOVED FROM LOCAL SURGERY
ANY OTHER REASONS

CONSENT FOR SMS: Yes No

EMAIL ADDRESS: _____

YOU WILL BE AUTOMATICALLY REGISTERED FOR ONLINE
SERVICES.

OCCUPATION: _____

NEXT OF KIN NAME, RELATIONSHIP AND CONTACT DETAILS:

MARITAL STATUS: _____ NUMBER OF CHILDREN: _____

ETHNICITY: _____ WHERE WERE YOU BORN? _____

WHEN DID YOU ARRIVE IN THE UK? _____

DO YOU REQUIRE AN INTERPRETER? Yes Language: _____

No First Language: _____

RELIGION: _____

ARE YOU A CARER?: Y/N IF SO WHO FOR? _____

ARE YOU CARED FOR? Y/N

DO YOU HAVE ANY CLOSE FAMILY HISTORY OF THE FOLLOWING? IF SO, PLEASE STATE WHICH FAMILY
MEMBER:

Heart Disease? Stroke? Hypertension? Diabetes? Asthma? Breast Cancer? Epilepsy?

Who..... Who..... Who..... Who..... Who..... Who..... Who.....

IF YOU HAVE ANY HISTORY OF SERIOUS OR CHRONIC ILLNESS OR OPERATIONS PLEASE GIVE DETAILS OF
THEM HERE:

IF NONE TICK HERE

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_____ / _____

IF YOU ARE CURRENTLY ON ANY MEDICATION, PLEASE ATTACH YOUR LAST REPEAT PRESCRIPTION SLIP
(Please book a new patient medical if you require medication, failure to do so may result in you being without your medication for a period of time)

IF NONE TICK HERE

IF YOU HAVE ANY MOBILITY, SIGHT AND HEARING DIFFICULTIES PLEASE GIVE DETAILS HERE

IF NONE TICK HERE

DO YOU CONSIDER YOURSELF TO HAVE ANY INFORMATION OR COMMUNICATIONAL NEEDS? E.G. SENSORY LOSS OR IMPAIRMENT. PLEASE GIVE DETAILS BELOW.

IF NONE TICK HERE

IN ORDER TO ENSURE WE MEET YOUR NEEDS PLEASE DETAIL BELOW WHAT WE CAN DO TO HELP.

IF YOU HAVE ANY ALLERGIES, PLEASE LIST THEM HERE

IF NONE TICK HERE

IF KNOWN, WHEN WAS YOUR LAST TETANUS INJECTION?

IF NOT KNOWN TICK HERE

HAVE YOU EVER SMOKED? Yes
No

If yes how many a day? _____

Are you interested in quitting? *NB. You can speak to one of our trained nurses for more information.*

No Ex-Smoker When did you quit? _____

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DO YOU DRINK ALCOHOL? Yes No
 Teetotaler Occasional/Light Drinker Moderate Heavy

IF YES PLEASE COMPLETE THE FOLLOWING AS PART OF A DEPARTMENT OF HEALTH REQUEST:

QUESTIONS	SCORING SYSTEM					YOUR SCORE
	0	1	2	3	4	
Q1. How often do you have 8 (men) / 6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only consider questions 2, 3 and 4 if the response to Q1 is Monthly or less						
Q2. How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q3. How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q4. Has a relative, friend, Doctor or Health Worker been concerned about your drinking or advised / suggested you to cut down?	No		Yes, but not in the last year		Yes, on more than one occasion	

WHAT IS YOUR HEIGHT _____ WEIGHT _____

ARE YOU AN EX SERVICE MEMBER? IF SO, PLEASE TICK BELOW.

ARMY ROYAL NAVY ROYAL AIR FORCE OTHER

WOMEN: PLEASE GIVE DATES AND DETAILS OF ANY PREGNANCIES:

WOMEN: WHEN WAS YOUR LAST SMEAR? WHAT WAS THE RESULT?

WOMEN: WHAT METHOD OF CONTRACEPTION DO YOU USE?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

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NHS Summary Care Record with additional information

If you are registered with a GP practice in England you will have a Summary Care Record (SCR), unless you have previously chosen not to have one. It includes important information about your health:

- Medicines you are taking
- Allergies you suffer from
- Any bad reactions to medicines

You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs. Having a SCR means that when you need healthcare you can be helped to recall vital information.

SCRs can help the staff involved in your care make better and safer decisions about how best to treat you.

You can choose to have additional information included in your SCR, which can enhance the care you receive. This information includes:

- Your illnesses and health problems
- Operations and vaccinations you have had in the past
- How you would like to be treated - such as where you would prefer to receive care
- What support you might need
- Who should be contacted for more information about you

What to do next

If you would like this information adding to your SCR (or the SCR of someone you are a carer for), then please complete this form, for return to the relevant GP surgery.

Name of Patient:

Date of Birth: Patient's Postcode:

Surgery Name: **St John's Surgery** Surgery Location (Town): **Terrington St John**

NHS Number (if known):

Signature: Date:

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name

Capacity

Please circle one

Parent	Guardian	Lasting Power of attorney for health and welfare
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If you require any more information, please visit www.hscic.gov.uk/scr/patient phone HSCIC on

0300 303 5678 or speak to your GP Practice.

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PATIENT THIRD PARTY CONSENT FORM

PATIENT'S NAME: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

NAME OF PERSON TO BE
CONSENTED: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

THE CONSENT OF THE PATIENT IS REQUIRED. PLEASE OBTAIN THE PATIENTS'S SIGNED CONSENT BELOW.

I fully consent to my Doctor releasing information to, and discussing my care and medical records with the person named above.

If there are any conditions and restrictions to the consent, please list below;

.....
.....

This authority if for an indefinite period / for a limited period only (*delete as appropriate*)
Where a limited period applies, this authority is valid until.....

Signed..... (*patient only*)

Date.....

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_____ / _____

What to expect as a patient at St Johns Surgery

- For **routine** appointments and general enquiries please call after 10.30am
- For **urgent** problems requiring an appointment on the same day please call at 8am
- We allocate a 10 minute appointment per problem – please request a double appointment at time of booking if there are 2 problems to discuss and so on
- Please be aware that reception will ask for your symptoms in order to book you an appointment with the appropriate clinician to deal with it. This is at the request of our Clinical Lead.
- The surgery operates a triage system which means you may be offered a telephone consultation rather than a face to face appointment
- We have three nurse prescribers who are able to assist patients with acute illnesses – a GP appointment is not always needed.
- If you are unable to attend an appointment, please contact us to either cancel or reschedule at your earliest convenience
- If a clinician asks you to make a follow up appointment, please book the appointment with reception when leaving the surgery.
- For simple illnesses such as coughs, colds etc, please seek advice from your local Pharmacist
- If medical advice is required outside of our opening times please call 111
- The surgery does not issue antibiotics on demand. They will only be prescribed in line with national guidance
- We will prescribe non-generic drugs in line with Norfolk & Waveney prescribing Guidelines to keep down the cost to the NHS
- Please be advised we do not deal with dental problems. Please contact your dentist, or 111 if you are not registered with one
- We do not accept medication requests over the telephone
- Medication requests must be made in writing
- Please allow 48 working hours for medication requests to be processed
- We do not offer a Smoking Cessation service – please contact your local pharmacy or call SmokeFree on 0300 123 1044
- We do not offer Travel Vaccinations – please contact your local Travel Clinic for advice
- Please ensure your contact details are kept up to date and provide us with a mobile number to allow the use of the SMS text messaging service
- We will not disclose any information about you to anyone, including family members. This includes (but not limited to) booked appointments, prescriptions and results
- If you wish us to discuss information about you with your partner or a family member, you must give us your consent in writing. Reception will provide the necessary 3rd Party Consent form for you to complete
- We aim to provide you with the best care. If you have concerns about any aspect of your care please contact the Practice Manager who will treat your concern in confidence

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_____ / _____