

CONFIDENTIAL MEDICAL REGISTRATION FORM

All patients registering at Mere Surgery will be allocated a named General Practitioner depending on their surname. Patients with a surname beginning with A-K will be allocated under Dr Halsey and patients with a surname beginning with L-Z will be allocated under Dr King. Patients are however free to see any doctor of their choice for each consultation although we would encourage you to see the same doctor for the duration of each problem to ensure continuity of care.

Online access to GP records is available for booking appointments, ordering repeat medication and to view information including immunisations, medications and test results. If you would like to have online access, please ask for an application form at reception.

Please complete all pages in FULL using BLOCK capitals

Surname

First Names (in full)

Previous Surnames

Title: Mr Mrs Miss Ms Other Male Female

Date of Birth (day/month/year) NHS Number

Town & country of Birth

Address Post Code:

Telephone number: Mobile number:

Reminders for appointments will be sent by SMS text messaging to the mobile number provided. We may also send SMS text messages or Emails to remind you about booking appointments for clinics or updating you on information about the surgery. Please advise reception if you want to opt out of this service.

Email address:

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

Your previous address in UK Post Code:

Name of previous Doctor while at that address

Address of previous Doctor Post Code:

Where did you last receive treatment?

Date:

ie GP, Walk in Centre, MIU, Emergency Department etc

What was the outcome of this visit? ie prescription

If you are from abroad:

Your first UK address where Registered with a GP

Post Code:

If previously resident in UK date of leaving

Date you first came to UK

Dispensing - If you live more than 1 mile in a straight line from the nearest chemist:

- I live more than 1 mile in a straight line from the nearest chemist and would like to collect my dispensed medications from the Dispensary at Mere Surgery

Non - Dispensing - If you live less than 1 mile in a straight line from the nearest chemist:

- I would like my prescriptions to be sent to Mere Pharmacy for collection
- I would like my prescriptions to be sent to the following pharmacy for collection (address including post code)

If you are returning from the Armed Forces:

Addresss before enlisting

Post Code:

Enlistment date

Service/
Personnel number

NHS Organ Donor registration:

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

- Any of my organs and tissue or
- Kidneys Heart Liver Corneas Lungs Pancreas Any part of my body

Signature to confirm agreement to organ/tissue donation is at the bottom of this form.

For more *information please ask at reception for an information leaflet or visit the website*
www.uktransplant.org.uk or call 0300 123 23 23

NHS Blood Donor registration:

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years

Signature to confirm consent to inclusion on the NHS Blood Donor Register at the bottom of this form.
 (For more information, please ask for the leaflet on joining the NHS Blood Donor Register. My preferred address for donation is (only if different from above eg your place of work))

..... Post code:

Please tell us about yourself:

Are you a carer? Yes No Do you have a carer? Yes No

If yes, please tell us the name & address of your Carer:

Are you happy for us to contact your carer about you? Yes No

Do you have any special communication needs? Yes No

If Yes: Sign Language Large Print Other

For patients aged 85 or over: (these are to help us assess if you may need additional clinical input)

In general, do you have any health problems that require you to limit your activities? Yes No
 In general, do you have any health problems that require you to stay at home? Yes No
 Do you regularly use a stick, walker or wheelchair to get about? Yes No
 In case of need, can you count on someone close to you? Yes No
 Do you need someone to help you on a regular basis? Yes No

Please provide details if the person is different from the information you have provided as your carer.

Personal Medical History.....

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	Year diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No

Family History.....

Have any close relatives (*father, mother, sister, brother only*) ever suffered from any of the following:
(please indicate who in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Immunisations

Immunisation	Year	Immunisation	Year
Tetanus		Polio	
Typhoid		Yellow Fever	
Hepatitis A		Hepatitis B	

Allergies

Please list any allergies you have to any drugs/medication:

Name of medication	What was the problem or upset?

List of current medication

If you have a copy of your repeat medications, please pass to Reception to copy

Name of medication	Dosage

Lifestyle

Please enter your height & weight:

Height:	Weight:
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Lifestyle smoking

Do you smoke: Yes No

If yes, do you smoke: Cigarette Cigars Pipe

Are you an ex-smoker? Yes No

When did you give up?

How many cigarettes/ cigars do you smoke daily? <1/day 1-9/day 10-19/day 20-39/day 40+/day

Would you like help to quit smoking? Yes (please make an appointment with the Smoke Stop Nurse) No

Lifestyle alcohol

Do you drink alcohol: Yes No If yes, please answer the following questions:

	0	1	2	3	4	Score
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How often do you have a drink that contains alcohol? Never Monthly Or less 2-4 times per month 2-3 times per week 4+ times per week

How many standard alcoholic drinks do you have on a typical day when you are drinking? 1-2 3-4 5-6 7-8 10+

How often do you have 6 or more standard drinks on one occasion? Never Less than Monthly Monthly Weekly Daily or almost daily

Lifestyle exercise

Do you exercise: Yes No
What exercise do you do?

If yes, please answer the following questions

How often do you exercise?

Blood Pressure monitoring

If you record your own blood pressure on a monitor at home please give us the latest recording and date it was taken.

Female patients only

Are you currently, or think you may be pregnant?

Yes No

Do you have any children?

Yes No If yes, how many?

Which method of contraception (if any) are you using at present?

Have you had a cervical smear test?

Yes No If yes, what was the result? (if known)
Date (if known)

Ethnicity

Please indicate your ethnic origin:

British or mixed British Irish African Caribbean Indian Pakistani

- Bangladeshi Chinese Other (please state):
 Decline to state

SUPPLEMENTARY QUESTIONS

Registration with a GP practice is not dependent on the answering of these questions.

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:		Relation ship to	

On behalf of:		patient:	
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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 EHC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a <u>non-UK</u> EHIC or PRC?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	If YES, please enter details from your EHIC or PRC below:	
	Country Code: 		
	3: Name		
	4: Given Names		
	5: Date of Birth	DD MM YYYY	
	6: Personal Identification Number		
	7: Identification number of 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 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 The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

Next of kin

Name: Tel. contact number:

Relationship:

Data sharing consent choices

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Details of how we share your information are found in the Privacy Notice available on our website or ask for a copy at reception.

If you wish to **OPT OUT** information is available at <https://www.nhs.uk/your-nhs-data-matters/> or ask for a form at reception.

Where you have provided information on how to contact you, can you confirm you are happy for Mere Surgery to contact you by the following:

By SMS text messaging Yes No Reminders for appointments, invitations to book into clinics and updating information about the surgery

By Email Yes No

Identification.....

For all patients registering at our practice we need to verify your identify by seeing 2 x proof of identification. These documents ideally should be:

	<i>For office use only</i>
Passport	
Driving Licence	
Birth Certificate	
Bank Statement	
Utility Bill	
Marriage Certificate	
Other	
Other	

If you are unable to provide any of the above or have difficulties obtaining them, please contact Reception who will be able to discuss other options with you.

Signature

I confirm that the information I have provided is true to the best of my knowledge.

Signed:

Date:

Signature of patient Signature on behalf of patient

If you need a large print version of this form please ask at reception.

Updated 27.06.2019