

New Patient Registration Form

Please complete this confidential form in **BLOCK CAPITALS** and tick the boxes as appropriate.

Complete a separate form for each family member to be registered.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and complete the section supplementary questions.

If patient is not ordinarily resident in the UK/Overseas Visitor please give leaflet 'Visiting the UK' and ensure section supplementary questions is completed and signed.

REGISTERING AT CHERRYMEAD SURGERY

Patients applying to join this practice's patient list must live within the practice area. Please check your address with Reception.

Return the completed form, **in person**, to the surgery together with one piece of photographic ID and one proof of address. Acceptable forms of ID:

- Current full passport
- Full UK photocard driving licence

Acceptable proof of address:

- Utility bill – gas/electric/water/or landline phone bill
- Tenancy agreement
- Council Tax bill
- Council rent book
- Household or motor insurance certificate
- HM Revenue & Customs documentation (e.g. PAYE coding notice/notification of working family or children's or disabled persons tax credit/HMRC tax calculation)
- Bank statement.

Patients aged under 16 years

No proof of address is required but unless there are exceptional circumstances, we will only register children in this age group if a parent/guardian is already a registered patient or in the process of registering. New babies should be registered using the New Baby Registration Form.

Failure to provide the required documentation may result in the refusal of your application

APPLICANT'S DETAILS – TO BE COMPLETED IN FULL AND IN BLOCK CAPITALS

NHS Number (if Known)	
Title:	
Surname:	
Forename(s):	
Date of Birth:	
Religion:	
Marital Status:	
Nationality:	
Ethnic Origin:	
First Language:	
Do you require an Interpreter?	YES / NO
If YES, please state language for translation:	
Gender	
Previous Surname(s):	
Telephone No (Home):	
Telephone No (Work):	
Telephone No (Mobile):	
Do you consent to us contacting you by text message?	YES / NO
Do you consent to us contacting you by email?	YES / NO
Email address: (PRINT CLEARLY)	
Current Address (incl Postcode)	
If returning from Armed Forces	
Your service or personnel Number and enlistment date:	
Your address before enlisting:	
If you are from abroad - Address where first registered with a GP and the date when you first came to live in the UK:	
If previously resident in UK – date of leaving:	

Previous Address - UK or Abroad (incl Postcode)	
Last Doctor's Name & Address - UK or Abroad (incl Postcode)	
Town and Country and Birth:	
Are you a carer for someone who is ill, frail, disabled or mentally ill?	
If you are registering a child under 5: I wish this child to be registered with Cherrymead Surgery for child health surveillance <input type="checkbox"/>	
Contact number for carer:	
Please sign here if you wish us to disclose information about your health to your Carer Signature	
If you have a "Living Will" (a statement explaining what medical treatment you would not want in the future). Please bring a copy to your first consultation	
Have you nominated someone to speak on your behalf? (e.g. a person who has power of attorney)	YES/NO
If you have answered yes , please give name and contact telephone number.	
The NHS is changing the way your health information is shared and managed. The NHS Summary Care Record is an electronic record of important information about your health. It will be available to health care staff providing your NHS Care. Please tick the box if you are happy to have a Summary Care Record. <input type="checkbox"/>	
Patient Participation –Cherrymead Surgery is committed to improving the services we provide to our patients. Are you interested in getting involved with our active Patient Reference Group that meets regularly at the surgery? <input type="checkbox"/> Tick the box and we will send you further details.	

NEW PATIENT QUESTIONNAIRE
MEDICAL HISTORY – TO BE COMPLETED IN FULL BY ALL PATIENTS

Current Medication: If None please write None

Medical Conditions: If None please write None

Cont'd.....

NEW PATIENT QUESTIONNAIRE
MEDICAL DETAILS – TO BE COMPLETED IN FULL BY ALL PATIENTS

Are you allergic or sensitive to any medicines, food, animals etc?	YES / NO
If yes, please give details:	

Have you ever smoked?	YES / NO	If yes, how many cigarettes smoked per day?	
Have you now stopped smoking?	YES / NO	If yes, please give approximate date:	
Are you interested in stopping?	YES / NO		

Current Height		Current Weight	
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Please list any **illnesses** that 'run in your family' (parents/siblings) eg Diabetes, Glaucoma, Heart Attacks etc. and state which family member has this illness:

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 boxes that apply:

Any organ or tissue
 Kidneys
 Heart
 Liver
 Corneas
 Lungs
 Pancreas
 Any part of body

Please sign to confirm your agreement to organ/tissue donation.

Signature _____ Date: / /

For more information visit the website: www.uktransplant.org.uk or www.blood.co.uk

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 confirming consent to inclusion on the NHS Blood Donor Register

Signature _____ Date: / /

My preferred address for donation is (only if different from above e.g. your place of work):

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If you need your doctor to dispense medicines and appliances*

I live more than 1 mile in a straight line from the nearest chemist **Not all doctors are authorised to dispense medicines*
 I would have serious difficulty in getting them from a chemist

Applicant's Signature	Date:
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These questions have been designed to speed up the receipt of your Medical Records and to assist your new General Practitioner in gaining an understanding of your medical history.

The information provided will be handled confidentiality but, should you have any concerns about completing any of the medical details, please leave them blank.

You will receive notification by email or letter as to whether your application has been accepted or rejected within two weeks of receipt of your application. If your application has been successful you will be informed of your 'Usual GP' and be given an appointment for a New Patient Registration Examination.

Please note that it is this Practice's policy to cancel the registration of new patients who fail to attend a New Patient Registration Examination within 3 months of applying to register with our Practice.

To be completed by the doctor

Doctors Name

HA Code

- I have accepted this patient for general medical services For the provision of contraceptive services
 I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above*

HA Code

- I am on the HA CHS list and will provide Child Health Surveillance to this patient or
 I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above*

HA Code

- I will dispense medicines/appliances to this patient subject to Health Authority's Approval
 I am claiming rural practice payment for this patient.
 Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances.

An audit trail is available at the practice for inspections by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature:

Name: _____ Date: ____/____/____

Practice Stamp

SUPPLEMENTARY 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:		Relationship to patient:	
On behalf of:			

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: <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: 	
	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

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 The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.