

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*

**Not all doctors are authorised to dispense medicines*

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

 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: 	
	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 Business Service Authority for the purpose of recovering your NHS costs from your home country.

HAWTHORN MEDICAL CENTRE

May Close, Cricklade Road, Swindon, SN2 1UU Tel: 01793 536541

www.hawthornmedicalcentre.co.uk

ADULT

New Patient Registration Questionnaire

Registration Desk Open Hours**Monday to Thursday Between 10.00 am – 12.30 pm****ALL PATIENTS 16 YEARS OR OLDER APPLYING TO REGISTER WITH THIS SURGERY ARE REQUIRED TO PROVIDE ONE PROOF OF IDENTITY AND ONE PROOF OF ADDRESS.*****EACH ADULT MUST ATTEND IN PERSON**

ID – A combination of the following documents may be accepted as identification – at least <u>one item of photo ID</u> is required for all adults over 16 years old.	<u>One Proof of Address</u> – needs to be dated within the preceding <u>3 months</u> :
Passport Driving Licence Visa Birth Certificate Marriage Certificate Papers from the Home Office Bus pass containing a photograph Identity card containing a Photograph	Gas Electric Council Tax Water Rates TV Licence Bank statement (with bank date stamp) Credit card or Catalogue statement

*We retain the right to refuse any application to Register at this surgery***Please complete all sections by writing clearly or by ticking relevant boxes.**

Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other <input type="checkbox"/>		Marital Status: _____	
Family Name: _____		Date of Birth: _____	
First Name: _____		Middle Name: _____	
Address: _____			
Home Telephone No: _____		Email: _____	
Mobile Telephone No: _____		Do you consent to receive SMS messages? YES / NO	
Preferred Method of Contact: Home Tel / Mobile / SMS (Text) / Letter – please circle one			

Have you previously been registered at this surgery? **Yes / No**

Please list other household members registered at this surgery

Name: Name:

Name: Name:

Ethnicity

White <input type="checkbox"/> White British <input type="checkbox"/> White Irish <input type="checkbox"/> White Other (please specify)	Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Asian Pakistani <input type="checkbox"/> Asian Chinese <input type="checkbox"/> Other (please specify)	Mixed <input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Other Mixed (please specify)
Black <input type="checkbox"/> Black Caribbean <input type="checkbox"/> Black African <input type="checkbox"/> Black Other	State Any Other Ethnic Group:	

What is your Main Spoken Language?	Do you speak English? YES / NO
------------------------------------	--------------------------------

Lifestyle information:

Smoking Status: **Current Smoker** **Ex-Smoker** **Never Smoked** (*delete as applicable*)

How many cigarettes per day?

Your Height:

Your Weight:

Alcohol screening: 1 DRINK= 1/2 pint of beer OR 1 glass of wine or 1 single spirit

<u>QUESTIONS</u>	<u>NEVER</u>	<u>LESS THAN MONTHLY</u>	<u>MONTHLY</u>	<u>WEEKLY</u>	<u>DAILY OR ALMOST DAILY</u>
<u>MEN:</u> How often do you have EIGHT or more drinks on one occasion? <u>WOMEN:</u> How often do you have SIX or more drinks on one occasion?					
How often during the last year have you been unable to remember what happened the night before because you had been drinking?					
How often during the last year have you failed to do what was normally expected of you because of drinking?					
In the last year has a friend/relative, or a doctor or other health worker been concerned about your drinking or suggested that you cut down?	<u>NO</u>		<u>Yes, on one occasion</u>		<u>Yes, on more than one occasion</u>

For office use only - received & validated by:

If you are on any REPEAT PRESCRIPTIONS from your previous doctor you must book an appointment with a doctor at this surgery before medication will be prescribed. Please bring your medication / repeat prescription order form with you to the appointment.

If you wish to be seen by a Practice Nurse for a general Health Check, please book an appointment at reception once registered.

Family Medical History

PLEASE SPECIFY FAMILY MEMBER WHO HAVE SUFFERED FROM:				
	Mother	Father	Brother	Sister
Angina	Y/N	Y/N	Y/N	Y/N
Heart Disease/Heart Attack	Y/N	Y/N	Y/N	Y/N
Diabetes	Y/N	Y/N	Y/N	Y/N
High Blood Pressure	Y/N	Y/N	Y/N	Y/N
Cancer (if yes, which type): -----	Y/N	Y/N	Y/N	Y/N

Next of Kin Details

Name:	Relationship:
-------	---------------

Address:	Contact Number:
----------	-----------------

Additional Next of Kin

Name:	Relationship:
-------	---------------

Address:	Contact Number:
----------	-----------------

Name:	Relationship:
-------	---------------

Address:	Contact Number:
----------	-----------------

Please ensure that you notify the Practice if any of these details change

<u>Signature</u>	<u>Date</u>
-------------------------	--------------------

DATA SHARING OPTIONS - The General Data Protection Regulations 2018

The General Data Protection Regulations 2018 (GDPR) came into force on 25th May 2018.

Summary Care Record

The regulations require that we gain patient consent regarding how we use your data. Specifically, whether you consent to having a Summary Care Record.

The Summary Care Record is a basic shared record across health care organisations.

It contains patient's medication, allergies and sensitivities and it may include enhanced information, for example for patients who are at the end of their life and the hospital, or a pharmacy may need urgent information about medications.

You have the right to opt out of the Summary Care Record.

Sharing In and Sharing Out – Enhanced Data Sharing Model

Your patient record includes medical history, details of your medication and any allergies/sensitivities you may have. You can now choose whether to share these full medical details with other health provider units eg. District Nurses, Health Visitors, Out of Hours Services.

You have 2 choices which give you control of how your record is shared. You can change these choices at any time by completing the consent form attached.

Sharing OUT

Information recorded at this Practice can be shared with other health care providers.

Sharing IN

You decide whether our Practice can see information in your record that has been entered by other services who are providing care for you or who may provide care for you in the future.

NATIONAL DATA OPT-OUT

The national data opt out is a service that allows patients to opt out of their confidential patient information being used for research and planning.

The national data opt out was introduced on 25 May 2018, enabling patients to opt out from the use of their data for research or planning purposes, in line with recommendations of the National Data Guardian in her Review of data security consent and opt outs.

Patients can view or change their national data opt out choice at any time by using the online service at www.nhs.uk/your-nhs-data-matters or by clicking on 'Your Health' in the NHS App, and selecting "Choose if data from your health records is shared for research and planning".

GP ONLINE SERVICES

You can now book appointments, order repeat prescriptions, and even access your GP records online. It's quick, easy and your information is secure. Register for online services at your GP surgery by speaking to a Receptionist or to find out more visit nhs.uk/GPonlineservices.

Hawthorn Medical Centre

Full Name	
Date of Birth	
Address including postcode	

Summary Care Record (Please tick one option below:)

Express consent for medication, allergies, and adverse reactions only	
Express consent for medication, allergies, adverse reactions, and additional information	
Express dissent – Patient does not want a summary care record and fully understands the risks involved with this decision	

PLEASE BE AWARE THAT IF YOU ATTEND ANY HOSPITAL, YOUR RECORDS WILL AUTOMATICALLY BE SHARED WITH THEM.

Sharing in and Sharing Out

Sharing OUT	
Please record whether you wish your full GP electronic record to be shared with other NHS Care Services where you are treated.	Yes/No

Sharing IN	
Please record whether you wish for our Practice to see information in your record that has been entered by other services who are providing care for you or who may provide care for you in the future.	Yes/No

<u>Signature</u>	<u>Date</u>
-------------------------	--------------------