

**REGISTERING AT ISLAND CITY PRACTICE**

Welcome to Island City Practice and thank you for your interest in registering as a new patient. Prior to completing a registration form, please ensure the following:

* You should only send this form to us if you are sure that you are eligible to join our practice.
* Sending this form will not automatically register you with the surgery.

If you are emailing this form to us, please note that by using this form you will be sending information about yourself across the internet. Whilst every effort is made to keep this information secure, you should be aware that we cannot offer any guarantee of absolute privacy. If this matter concerns you then you should hand in the forms in at reception.

If you require on the day treatment, our duty team run a triage service all day. Please be aware, our care navigation team will ask for a brief outline of the problem, this is to ensure that those people who require treatment sooner are dealt with in an appropriate length of time. You might also be signposted to a more appropriate service, for example physiotherapy, pharmacy, or dentist. If the clinician feels you require a face-to-face appointment, they will arrange this with you.

The surgery offers face to face services when they are essential, e.g. when a clinician needs to physically examine you. Patients with long term conditions, for example diabetes or asthma, will be invited in by the practice for a yearly annual review. Please see our website or ask at reception for more information.

All appointments can be booked by calling the surgery.

We understand how important it is to keep your personal information safe and secure. With the introduction of GDPR, it allows patients to see how we use your personal and healthcare information. We would ask that you view our privacy notice before completing this registration.

**PLEASE SIGN BELOW TO CONFIRM THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.**

Patient Name:

Patient Signature:

Date:

**ABOUT YOU**

***PLEASE WRITE IN CAPITAL LETTERS AND BLACK INC – Those marked with \* are essential.***

|  |  |
| --- | --- |
| \*TITLE *(Mr / Miss / Mrs / Dr / Other):* |  |
| \*FORENAME |  |
| MIDDLE NAME*(S)* |  |
| \*SURNAME |  |
| PREVIOUS SURNAME*(S)* |  |
| KNOWN AS / PREFERRED NAME |  |
| \*DATE OF BIRTH |  |
| \*GENDER *(Male / Female / Other)* |  |
| NHS NUMBER *(if known)* |  |
| \*PREVIOUS GP & ADDRESS |  |
| \*TOWN & COUNTRY OF BIRTH |  |
| \*IF NOT BORN IN UK DATE OF ENTRY INTO UK |  |
|  |
| \*CURRENT ADDRESS |  |
| \*POST CODE |  |
| \*HOME TELEPHONE |  |
| \*MOBILE NUMBER |  |
| EMAIL ADDRESS |  |
| PREFERRED METHOD OF CONTACT *(Phone / SMS / E-Mail / Post)* |  |
|  |
| MARITAL STATUS *(Single / Married / Living Together / Divorced / Widowed)* |  |
| RELIGION |  |
| \*MAIN SPOKEN LANGUAGE |  |
| \*DO YOU REQUIRE AN INTERPRETER? |  |
| \*ETHNICITY |

|  |  |
| --- | --- |
| WHITE BRITISH [ ] BRITISH[ ] IRISHMIXED or MIXED BRITISH[ ] WHITE & BLACK CARIBBEAN[ ] WHITE & BLACK AFRICAN[ ] WHITE & ASIAN[ ] OTHER:  | ASIAN or BLACK BRITISH[ ] INDIAN[ ] PAKISTANI[ ] BANGLADESHI[ ] CHINESEBLACK or BLACK BRITISH[ ] CARIBBEAN[ ] AFRICAN  |

 |

**HM FORCES**

|  |  |
| --- | --- |
| HAVE YOU PREVIOUSLY SERVED IN THE ARMED FORCES? | **[ ]** YES [ ] NO |
| ARE YOU A MILITARY RESERVIST? | [ ] YES [ ] NO |
| IF YES PLEASE STATE *(Army / Navy / Airforce etc.)* |  |
| EX-FORCES ONLY | DATE OF ENLISTMENT:DISCHARGE DATE:IF THIS IS YOUR ***FIRST***GP REGISTRATION, PLEASE ATTACH YOUR DISCHARGE MEDICAL RECORDS |
| DO YOU HAVE A FAMILY MEMBER CURRENTLY IN THE MILITARY SERVICE? | [ ] YES [ ] NO |
| ARE YOU A WAR WIDOW OR WIDOWER? | [ ] YES [ ] NO |

**NEXT OF KIN & FAMILY DETAILS**

|  |  |
| --- | --- |
| \*NEXT OF KIN FULL NAME |  |
| \*RELATIONSHIP TO YOU |  |
| \*TELEPHONE NUMBER |  |
| \*ARE THEY REGISTERED AT ISLAND CITY PRACTICE? | [ ] YES [ ] NO |
| PLEASE LIST ANY FAMILY MEMBERS REGISTERED AT THE PRACTICE *(Name & Relationship)* |  |

**CARER INFORMATION**

|  |  |
| --- | --- |
| ARE YOU A CARER? *(Formal or Informal)* | [ ] YES [ ] NO |
| DO YOU HAVE A CARER OR SOMEBODY THAT LOOKS AFTER YOU? | [ ] YES [ ] NO |
| \*ARE YOU HOUSEBOUND? | [ ] YES [ ] NO |
| CARERS NAME |  |
| TELEPHONE NUMBER |  |

**MEDICAL HISTORY**

|  |  |
| --- | --- |
| \*PLEASE GIVE DETAILS OF ANY CURRENT MEDICAL ISSUES |  |
| \*HAVE YOU EVER STRUGGLED WITH DRUG OR ALCOHOL MISUSE? IF SO, PLEASE GIVE DETAILS |  |
| \*DO YOU SUFFER FROM ANY OF THE FOLLOWING MEDICAL CONDITIONS? |

|  |  |
| --- | --- |
| [ ] HEART ATTACK [ ] HIGH BLOOD PRESSURE[ ] ASTHMA[ ] STROKE or MINI STROKE *(TIA)*[ ] DIABETES | [ ] EPILEPSY[ ] BLINDNESS/GLAUCOMA[ ] THYROID DISEASE[ ] COPD[ ] CANCER |

 |
| HAVE ANY OF YOUR CLOSE RELATIVES HAD? *(Please state which relative)* |

|  |  |
| --- | --- |
| [ ] HEART ATTACK *Relative:*  [ ] HIGH BLOOD PRESSURE*Relative:* [ ] ASTHMA*Relative:* [ ] STROKE or MINI STROKE *(TIA)**Relative:* [ ] DIABETES*Relative:*  | [ ] EPILEPSY*Relative:* [ ] BLINDNESS/GLAUCOMA*Relative:* [ ] THYROID DISEASE*Relative:* [ ] COPD*Relative:* [ ] CANCER*Relative:*  |

 |
| \*PLEASE GIVE DETAILS WITH DATES OF ANY OPERATIONS / ILLNESSES YOU HAVE HAD |  |
| \*DO YOU SUFFER FROM ANY ALLERGIES? | [ ] NO [ ] YES- PLEASE STATE:  |

**CURRENT MEDICATION**

|  |
| --- |
| If you are on any repeat medication, we ask that you have enough medication to last you at least a month. This then gives us enough time to receive your medical records from your previous surgery. To order your medication we encourage the use of SystmOnline or via the NHS app. You can also request your repeat medication through your nominated pharmacy. Please note we do not take medication requests over the phone.  |
| \*ARE YOU CURRENTLY TAKING ANY REGULAR MEDICATION? | [ ] YES [ ] NO |
| **IF YES PLEASE ATTACH A REPEAT MEDICATION SLIP** |
| We encourage our patients to sign up to electronic prescriptions. This is where we automatically send your prescriptions to your nominated pharmacy, so you no longer need to come and collect from the surgery. PLEASE STATE WHICH PHARMACY YOU USE:  |

**GENERAL HEALTH INFORMATION**

***PLEASE COMPLETE AS MUCH OF THE BELOW AS POSSIBLE, IF NOT APPLICABLE PLEASE LEAVE BLANK.***

|  |  |  |  |
| --- | --- | --- | --- |
| HOW OFTEN DO YOU HAVE A DRINK CONTAINING ALCOHOL? |

|  |  |
| --- | --- |
| [ ] N/A [ ] NEVER[ ] MONTHLY OR LESS | [ ] 2 – 4 TIMES A MONTH[ ] 2 – 3 TIMES A WEEK[ ] 4 OR MORE TIMES A WEEK |

 |
| HOW MANY UNITS OF ALCOHOL DO YOU DRINK ON A TYPICAL DAY WHEN DRINKING? |

|  |  |
| --- | --- |
| [ ] N/A [ ] 1 – 2 [ ] 3 – 4  | [ ] 5 – 6 [ ] 7 – 9 [ ] 10 OR MORE |

 |
| HOW OFTEN HAVE YOU HAD 6 OR MORE UNITS *(if female),* OR 8 OR MORE UNITS *(if male),* ON A SINGLE OCCASION IN THE LAST YEAR? |

|  |  |
| --- | --- |
| [ ] NEVER [ ] LESS THAN MONTHLY[ ] MONTHLY | [ ] WEEKLY[ ] DAILY OR ALMOST DAILY |

 |
| ARE YOU: |

|  |  |
| --- | --- |
| [ ] NEVER SMOKED TOBACCO [ ] SMOKER – HOW MANY DAILY? | [ ] EX SMOKER – WHEN DID YOU QUIT? |

 |
| ARE YOU INTERESTED IN QUITTING SMOKING? | [ ] NO[ ] YES – PLEASE SPEAK TO A MEMBER OF STAFF FOR MORE INFORMATION |
| DO YOU USE AN ELECTRONIC CIGARETTE? | [ ] YES [ ] NO |
| WEIGHT: HEIGHT: BLOOD PRESSURE: |
| DO YOU PARTAKE IN ANY EXERCISE? | [ ] NONE [ ] LIGHT [ ]  MODERATE [ ] HEAVY |

**\*\* FEMALE PATIENTS ONLY\*\***

|  |  |
| --- | --- |
| \*ARE YOU PREGNANT? | [ ] NO [ ] YES – EXPECTED DUE DATE: |
| PLEASE GIVE DETAILS OF ANY PAST PREGNANCIES |  |
| PLEASE STATE YOUR CURRENT METHOD OF CONTRACEPTION |  |
| DATE OF LAST CERVICAL SMEAR  |  |
| HAVE YOU EVER HAD A MAMMOGRAM? |  |

**TEXT REMINDERS & APPLICATION FOR ONLINE ACCESS**

This service will allow Island City Practice to contact you via text message for the following:

1. Sending you appointment reminders.
2. Receiving information about new services (for example invitations for vaccines).
3. Sending guidance and links.

We agree to adhere to the following:

1. All contact details held by the practice will only be used by the practice to deliver health care and will not be passed to any other parties. You will not be contacted in relation to other types or products or services.
2. If at any time you would like to opt out of this service, please make a personal request to the practice and we will remove your permission within 48 hours.
3. If at any point contact number is to change, please inform us as soon as possible.

***PATIENT NAME:***

***PATIENT SIGNITURE:***

All patients can have access to their medical records, appointment booking, requesting medication, questionnaires, summary record access and full clinical record access using online services.

If you are aged 11-16 and wish to have access to your online account, please speak to a member of staff.

By signing below you are agreeing to the following conditions:

* I accept responsibility for the password and any access to the system using the password.
* I am aware that if I divulge the password or allow access to the system to third parties then they will be able to access personal information about me.
* I agree to inform the practice immediately if I believe that my login details have been lost or stolen.
* The practice can cancel my access (without notification) if there is abuse of the system, such as:
* Booking appointments and not attending.
* Repeatedly booking and then cancelling appointments.
* Repeatedly requesting prescriptions that I do not need.

***PATIENT NAME:***

***PATIENT SIGNITURE:***

**INFORMATION SHARING**

*If you would like any further information about anything below, please ask at Reception*

Information on how we share your data can be found in our leaflet “How we use your data” or attached to the end of this form.

I agree to my information in my medical record being shared in accordance with the fair processing guidelines in the attached leaflet and I am aware that any updates or changes will be published on the Practice Website.

***PATIENT NAME:***

***PATIENT SIGNITURE:***

**SUPPLEMENTARY QUESTIONS**

*For all patients who are not ordinarily residents 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 13.

Signature: Date:

Name:

Relationship to Patient if under 13 years:

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

**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.**

|  |  |
| --- | --- |
|  | 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 |

Do you have a non-UK EHIC or PRC (if yes, please enter details below):Yes [ ]  No [ ]

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: From (DD/MM/YYYY) To (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 RC 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.**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*FOR SURGERY/OFFICE USE ONLY\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

IDENTITY VERIFICATION

|  |  |
| --- | --- |
| BIRTH CERTIFICATE | [ ] YES [ ] NO  |
| PASSPORT | [ ] YES [ ] NO  |
| DRIVING LICENSE | [ ] YES [ ] NO  |
| MARRIAGE CERTIFICATE | [ ] YES [ ] NO  |
| BANK STATEMENTOTHER:  | [ ] YES [ ] NO  |

IDENTIFICATION SEEN BY:

DATE:

Date of Receipt: Initials:

Doctors Name: HA Code:

[ ]  I have accepted this patient for this patient for general medical services

[ ]  I am on the HA CHS list and will provide Child Health Surveillance to this patient

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 Feed and Allowances. An audit trail is available at the practice for inspection by the HA’s authorised officers and auditors appointed by the Audit Commission.

Doctors Signature: Date:

*Main Site: Island City Practice, Lake Road Health Centre, Nutfield Place, Portsmouth, Hampshire, PO1 4JT*