

LAKE ROAD PRACTICE – NEW PATIENT REGISTRATION

It is important that we have up to date background health information on all our patients, we therefore ask you to complete as much of this form as you can – **using black ink only.**

ABOUT YOU

Title (Mr / Miss / Mrs / Dr / Other): Forename:

Middle name(s): Surname:

Previous Surname(s):

NHS Number: Gender: Male Female

Date of Birth (DD/MM/YYYY):

Place and Country of Birth:

Date of Entry into the UK (DD/MM/YYYY): From Birth

First Spoken Language:

Other Spoken Languages:

Current Home Address: Previous UK Home Address (if applicable):

.....

.....

Post Code: Post Code:

E-mail Address:

Home Number: Mobile Number:

Have you previously been registered with a GP in the UK? Yes No

If yes, Name and address of last UK GP:

.....

If you have been registered at Lake Road Practice before, please tick here:

Do you look after somebody with a medical need? If so, who and how are you related?

.....

Have you previously served in the armed forces? Yes No

If yes, date of enlistment: Date of discharge:

If yes, service personnel number:

Are you a war widow/widower? Yes No

MEDICAL DETAILS

Please give details of any current medical issues (e.g. pregnancy, infection):

.....

Have you ever struggled with drug or alcohol misuse? If so, please give details:

.....

Please list any allergies to medication, food or animals or tick none: None

.....

.....

Please give some details of your medical history?

Have you ever had?	✓	Have any of your close relatives had?	✓	Which relative?
Heart Attack	<input type="checkbox"/>	Heart Attack (under 60)	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	
Stroke or Mini stroke (TIA)	<input type="checkbox"/>	Stroke or Mini Stroke (TIA)	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	
Blindness/Glaucoma	<input type="checkbox"/>	Blindness/Glaucoma	<input type="checkbox"/>	
Thyroid disease	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	

Please give details with dates of any operations/ illnesses you have had:

.....

.....

What is your current smoking status?

Never Smoked

Ex-Smoker

Smoker

How would you describe your weekly exercise?

Light

Moderate

Heavy

Unable

Would you like us to send you information about becoming a Blood or Organ Donor?

Blood Donor

Organ Donor

Both

None

WOMEN ONLY

When was you last cervical smear (DD/MM/YYYY)?

Was it normal? Yes No

Which form of contraception do you use? None Pill Depo Coil Implant

Other?

Was this issued by your last GP? Yes No

Please give details of any past pregnancies:

.....

Have you ever had a mammogram? Yes No

Details:

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 outline in the attached leaflet and I am aware that any updates and changes will be published in the Practice Website: Yes

PHARMACY NOMINATION

We can now send your prescriptions to the pharmacy electronically for you, reducing the amount of paper used and making collecting your prescription easier for you. Please fill in the details below so that we can add them to the system. We will clear any previously nominated pharmacy as part of our registration process so you will need to complete the section below, even if you already have a nominated pharmacy.

I would like my prescriptions to be sent electronically: Yes

Pharmacy name and address:

ETHNICITY

<u>White</u>	<u>Mixed or Mixed British</u>	<u>Asian or Black British</u>	<u>Black or Black British</u>	<u>Other</u>
<input type="checkbox"/> British	<input type="checkbox"/> White & Black Caribbean	<input type="checkbox"/> Indian	<input type="checkbox"/> Caribbean	
<input type="checkbox"/> Irish	<input type="checkbox"/> White & Black African	<input type="checkbox"/> Pakistani	<input type="checkbox"/> African	
	<input type="checkbox"/> White & Asian	<input type="checkbox"/> Bangladeshi		
		<input type="checkbox"/> Chinese		

OTHER

Please list any family members registered at the Practice (name and relationship):

.....
.....

If this registration is for a person less than 16 years old, please give name and contact details of the Parent/Guardian:

.....
.....

Does the person registering have any specific communication needs that we should be aware of?

.....
.....

PATIENT SIGNATURE (or parent/guarding for under 16s)

If you are on any repeat medications from your previous GP please provide a copy of the repeat slip when you hand in your registration form.

Signature: Date:

Name:

Relationship to Patient:

STAFF USE ONLY

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 Fee 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:

Lake Road Practice, Nutfield Place, Portsmouth, Hampshire, PO1 4JT

SUPPLEMENTARY QUESTIONS - 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.

PATIENT SIGNATURE

If you are on any repeat medications from your previous GP please provide a copy of the repeat slip when you hand in your registration form.

Signature: Date:

Name:

Relationship to Patient:

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.