

Patient's details

 Please complete in BLOCK CAPITALS and tick as appropriate

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Surname
Date of birth	First names
NHS No.	Previous surname/s
<input type="checkbox"/> Male <input type="checkbox"/> 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
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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*

<input type="checkbox"/> I live more than 1.6km in a straight line from the nearest chemist <input type="checkbox"/> I would have serious difficulty in getting them from a chemist <input type="checkbox"/> Signature of Patient <input type="checkbox"/> Signature on behalf of patient	*Not all doctors are authorised to dispense medicines
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Date / /

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

 Signature confirming my consent to join the NHS Organ Donor Register Date / /
Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.
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 my consent to join the NHS Blood Donor Register Date / /

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

 Postcode:
All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.
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 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 <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:
 <p>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.</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.

Broadwater Medical Centre
New Patient Registration Form

Broadwater Medical Centre
5-11 Broadwater Boulevard, Worthing,
West Sussex, BN14 8JE
01903 826926



Included in this pack are a number of forms.
Please fully complete all of these.

Identification

When returning this pack, please ensure you bring with you **two forms of ID:**

- **1 x photographic ID** e.g. passport, driver's license, bus pass etc.
This is mandatory for online access
- **1 x proof of address** that you are currently living at e.g. utility bill, council tax, tenancy agreement, bank statement etc.

Please note: proof of address must be **no more than 3 months old**

Please ensure you fill in your NHS number on the purple GMS form

If registering someone under 16 years old, a passport or birth certificate will be required.

FOR OFFICIAL USE:

ID/proof of address seen: YES NO

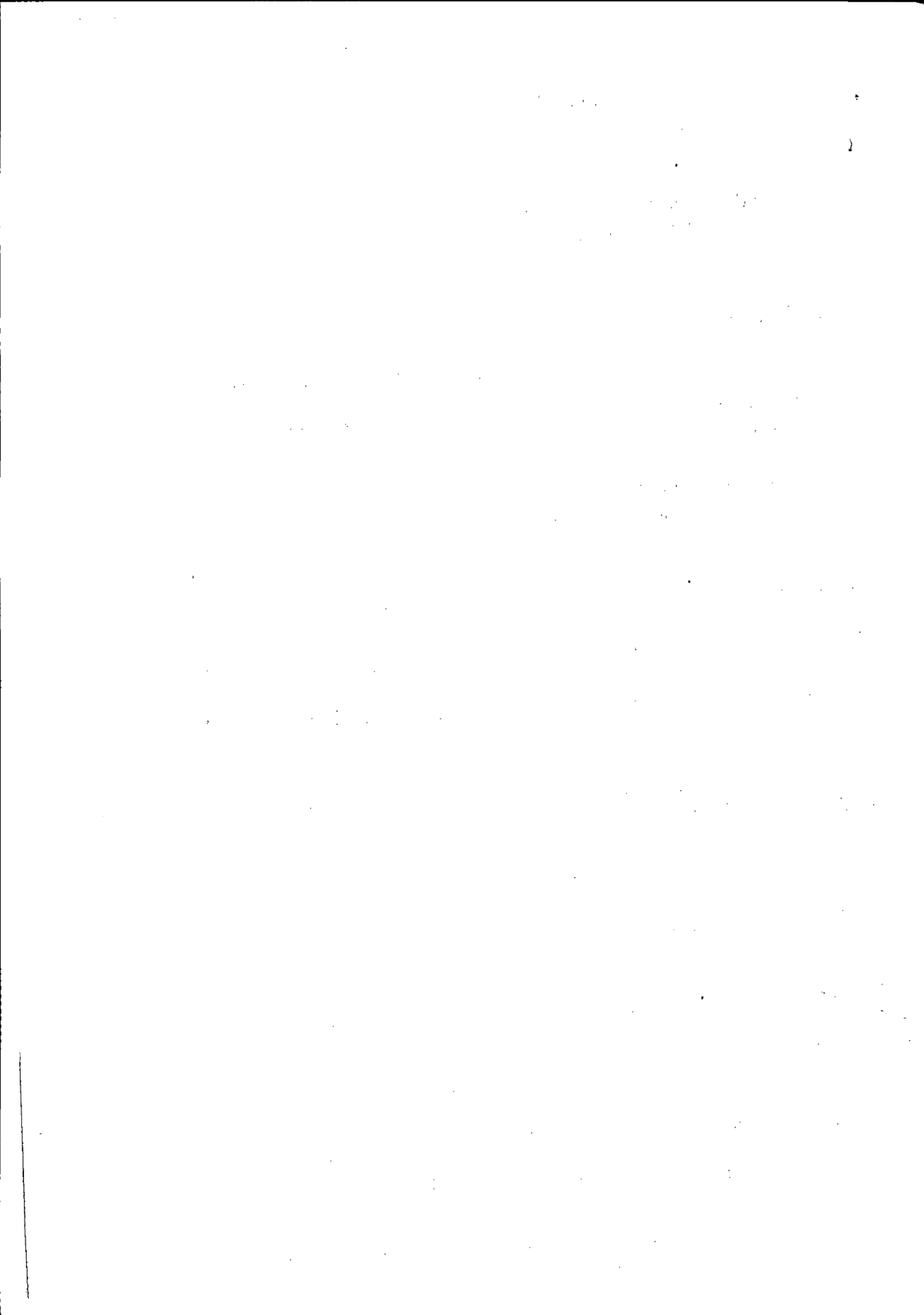
Type: _____

Name of receptionist: _____ date: _____

Online access requested: YES NO

Electronic prescription nominated pharmacy received: YES NO

Consent to share data: YES NO



New Patient Health Data

First name		Surname	
Date of Birth		Ethnic Origin	
Address			
Postcode		First Spoken Language	
Home Tel Number		Mobile Tel Number	

I give consent to the surgery sending me a text message: YES / NO

E-Mail Address: _____

I give consent to the surgery emailing me: YES / NO

Do you have a carer? YES / NO
Name of carer: _____ Relationship: _____
Are you a carer? YES / NO
Name of person you care for: _____ Relationship: _____

Height and Weight

Height: _____

Weight: _____

Blood Pressure

If you are 16 or over, please take your blood pressure using the blood pressure machine in the reception area. The machine will print out your reading on a ticket, please fill in your reading here or hand it to reception with your registration form.

Systolic: _____

Diastolic: _____

Pulse: _____

Signature: _____

Date: _____

First name:		Surname:		DOB:	
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Family History

Family Member	Breast Cancer Y/N	Heart Disease		Stroke Y/N	High BP Y/N	Asthma Y/N	Diabetes Y/N
		Under 60 Y/N	Over 60 Y/N				

Allergies

Drug Allergy: _____ Non-Drug Allergy: _____

Smoking

I am a current smoker I have never smoked I am an ex-smoker

If you are an ex-smoker, in which year did you give up? _____

If you are a smoker, how many do you smoke a day? _____

Smoking is detrimental to your health. We provide a smoking cessation service; please ask for a smoking cessation form when registering.

Alcohol

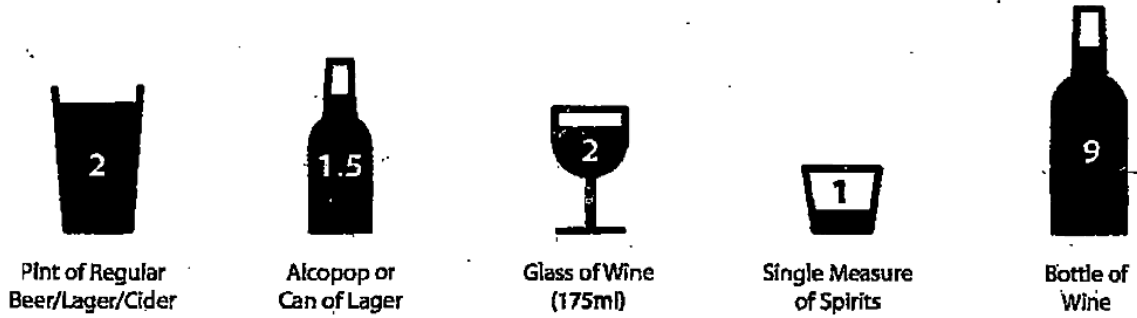
Standard glass of wine (175ml) = 2.3 units
 Regular strength pint of beer/cider/lager = 2.3 units
 Single spirit (25ml) = 1 unit

Alcohol Consumption: _____ units per week

First name: _____ Surname: _____ DOB: _____

This brief intervention package is based on the Drink-Less programme originally developed at the University of Sydney as part of a W.H.O. collaborative study.
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UNITS



Alcohol Users Disorders Identification Test (AUDIT)

Questions	Scoring System					Your Score
	0	1	2	3	4	
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	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0-7 = sensible drinking, 8-15 = hazardous drinking, 16-19 = harmful drinking and 20+ = possible dependence

How much is too much?

Screening Tools

First name:		Surname:		DOB:	
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Online Access

We offer all our patients online access so that you can book and cancel GP appointments, order repeat prescriptions and have access to a summary of your records. This can help reduce the amount of patients that do not attend and can be convenient for those wanting to request medication over the weekend. Please tick the box if you require a username and password for this access.

*If you require online access, you will need to bring photographic ID 5 working days after registering for us to issue this for you.

- I wish to have online access*
- I do not wish to have online access*

Electronic Prescriptions

Repeat prescriptions are now sent straight to pharmacies electronically. This makes the process quicker and more efficient for both patients and the surgery.

I would like my prescriptions to be sent electronically to _____

Sharing Data

To help provide the best care to our patients we may need to share your details with other healthcare providers when appropriate, for example the local hospital or community services.

- I give consent to share my records*
- I do not give consent to share my records*