



ADULT REGISTRATION FORM

Please fill in all the sections below using **BLOCK CAPITALS**

If you need someone to help you complete this form please speak to our reception team.

If you need to add additional pages to this form please attach them to the form and tick this box

All information recorded on these forms will be stored electronically on your medical record.

This information will be strictly confidential and will never be shared without your consent.

FULL NAME:	
DATE OF BIRTH:	
HOME ADDRESS:	
MOBILE NUMBER:	
OTHER NUMBER(S):	
EMAIL ADDRESS:	

By providing a mobile number you agree to be contact via free text messages from the practice. This could be from a clinician or other member of staff and will also include appointment reminders. If you wish to opt out of this please tick this box:

ETHNIC ORIGIN:	<input type="checkbox"/> British/Mixed British	<input type="checkbox"/> Irish
	<input type="checkbox"/> Other White Background	<input type="checkbox"/> White & Black African
	<input type="checkbox"/> White & Black Caribbean	<input type="checkbox"/> Black African
	<input type="checkbox"/> Black Caribbean	<input type="checkbox"/> Other Black Background
	<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> Indian
	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Chinese
	<input type="checkbox"/> White & Asian	<input type="checkbox"/> Other Asian Background
	<input type="checkbox"/> Other Mixed Background	<input type="checkbox"/> Rather Not Say
	<input type="checkbox"/> Other (Please Specify)	
RELIGION:		<input type="checkbox"/> Rather Not Say
MARITAL STATUS:		<input type="checkbox"/> Rather Not Say
SEXUALITY:		<input type="checkbox"/> Rather Not Say
GENDER IDENTITY & PREFERRED PRONOUNS		<input type="checkbox"/> Rather Not Say
SPOKEN LANGUAGE:		
DO YOU REQUIRE AN INTERPRETER?	<input type="checkbox"/> YES <input type="checkbox"/> NO	

ARE YOU A MILITARY VETERAN?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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KNOWN DISABILITIES, HEALTH CONDITIONS OR ALLERGIES:			
DO YOU REQUIRE ANY COMMUNICATION SUPPORT?	<input type="checkbox"/> Sign Language Interpreter	<input type="checkbox"/> Deaf-Blind Interpreter	
	<input type="checkbox"/> Advocate	<input type="checkbox"/> Speech to Text Reporter	
	<input type="checkbox"/> Other Interpreter/Accessible Support (Please Specify)		
DO YOU HAVE DIFFICULTY READING OR WRITING?	<input type="checkbox"/> YES <input type="checkbox"/> NO	PLEASE LET THE RECEPTIONIST KNOW HOW YOU WOULD PREFER TO BE CONTACTED	
ARE YOU REGISTERED DISABLED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU HAVE A CARER?	<input type="checkbox"/> YES <input type="checkbox"/> NO
CARER NAME:		CARER CONTACT:	
DO YOU GIVE CONSENT FOR YOUR CARER TO DISCUSS YOUR MEDICAL RECORD?			<input type="checkbox"/> YES <input type="checkbox"/> NO

ARE YOU A CARER?	<input type="checkbox"/> YES <input type="checkbox"/> NO
WHO DO YOU CARE FOR?	

DO YOU SMOKE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
WOULD YOU LIKE HELP TO QUIT?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT APPLICABLE
ARE YOU EXPOSED TO SMOKE AT WORK OR IN YOUR HOME?	<input type="checkbox"/> YES <input type="checkbox"/> NO

ARE YOU ON ANY MEDICATION?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES PLEASE OBTAIN A CURRENT LIST FROM YOUR PREVIOUS GP SURGERY AND ASK THEM TO ORDER ANY REPEAT MEDICATIONS THAT ARE DUE SOON You must bring this with you to your New Patient Health Check appointment with the nurse	

NEXT OF KIN DETAILS

NAME:	
CONTACT NUMBER:	
RELATIONSHIP TO PATIENT:	
CONSENT TO DISCUSS MEDICAL RECORD?	<input type="checkbox"/> YES <input type="checkbox"/> NO

CONTACT PREFERENCE(S):	<input type="checkbox"/> PHONE <input type="checkbox"/> SMS <input type="checkbox"/> POST <input type="checkbox"/> EMAIL <input type="checkbox"/> VIA CARER/NEXT OF KIN
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SIGNATURE:	
DATE:	

Please make sure to also sign the purple GMS1 form attached to this registration pack

ACCEPTABLE FORMS OF ID

- Passport Driving License Birth Certificate
AND
 Utility Bill Council Tax Statement Bank Statement

A copy of these will be taken and stored electronically with your medical record – we will only copy relevant information and once this is scanned to record it will be destroyed confidentially. If you are struggling to provide this information please speak to a member of staff at reception.

For more information regarding our confidentiality, dignity, equality or privacy policies please contact Hope Citadel Healthcare CIC via info@hopecitadel.org.uk

NEXT STEPS:

- Once you have handed this to our reception team you will be registered in the next 48 working hours
- You will need to book a new patient medical with our healthcare assistant before you can book routine GP appointments
- If you require an urgent GP appointment before this new patient medical you must phone on the day you require at 8am
- If you do not attend a new patient medical you may be removed from the practice register
- It is your responsibility to keep your contact details up to date to ensure that we are able to contact you when necessary – forms are available at reception to update your details at any time.

FOR OFFICE USE ONLY

TAKEN IN BY		DATE	
ID SEEN/COPIED	<input type="checkbox"/> YES <input type="checkbox"/> NO	NPM DATE	
REGISTRATION DATE		EMIS NUMBER	