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.

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.

We understand that some of the requested information is sensitive – only questions marked with (*) are mandatory for the registration process. Please answer as many questions as you can as this will help the practice provide you the best possible care

***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:**	☐ British/Mixed British	☐ Irish
	☐ Other White Background	☐ White & Black African
	☐ White & Black Caribbean	☐ Black African
	☐ Black Caribbean	☐ Other Black Background
	☐ Bangladeshi	☐ Indian
	☐ Pakistani	☐ Chinese
	☐ White & Asian	☐ Other Asian Background
	☐ Other Mixed Background	☐ Rather Not Say
	☐ Other (Please Specify)	
RELIGION:		
MARITAL STATUS:		
SEXUALITY:		
HOW WOULD YOU DESCRIBE YOU GENDER?	☐ Male (inc. trans male)	☐ Non-binary
	☐ Female (inc. trans female)	☐ Other (please state)
IS YOUR GENDER DIFFERENT TO THE ONE YOU WERE ASSIGNED AT BIRTH?	☐ YES ☐ NO	
***SPOKEN LANGUAGE:**		
***DO YOU REQUIRE AN INTERPRETER?**	☐ YES ☐ NO	

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

ARE YOU A CARER?	☐ YES ☐ NO
WHO DO YOU CARE FOR?	

DO YOU SMOKE?	☐ YES ☐ NO
WOULD YOU LIKE HELP TO QUIT?	☐ YES ☐ NO ☐ NOT APPLICABLE
ARE YOU EXPOSED TO SMOKE AT WORK OR IN YOUR HOME?	☐ YES ☐ NO

***ARE YOU ON ANY MEDICATION?**	☐ YES ☐ 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?	☐ YES ☐ NO

CONTACT PREFERENCE(S):	☐ PHONE ☐ SMS ☐ POST ☐ EMAIL ☐ VIA CARER/NEXT OF KIN

***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 confidentially, 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 PRACTICE USE ONLY

TAKEN IN BY		DATE	
ID SEEN/COPIED	☐ YES ☐ NO	NPM DATE	
REGISTRATION DATE		EMIS NUMBER	

PATIENT ONLINE: REGISTRATION FORM

Access to GP online services

Please complete this form and hand it to the practice, please also provide proof of identity. Please note that each individual family member would need to complete this application form as each individual needs to have their own account – child accounts require a separate form. Once we have received this completed form we will contact you to arrange for account set up details to be sent to you.

Name	
DOB	
Address	
Telephone Number	
Mobile Number	
Email Address *please print clearly*	

By providing your mobile number you are consenting to receiving **FREE** text reminders of your appointments and occasional SMS contact by the practice. Birtle View Medical Practice will not contact you unnecessarily or give your details to unauthorised third parties. If you **DO NOT** want to be contacted via SMS or receive appointment reminders please tick this box: ☐

I wish to have access to the following online services (tick all that apply):

1. Booking appointments	☐
2. Requesting **repeat** prescriptions	☐
3. Access to my Core Summary Record (medications and allergies)	☐
**Please ask for a further application form if you wish to request access to your detailed coded information*	
1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, it is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me, or is inaccurate, I will log out immediately and contact the practice as soon as possible	☐

Patients Signature	
Date	

FOR PRACTICE USE ONLY

Identity verified through *(tick all that apply)*	Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐	**Name of verifier**	**Date**
Name of person who Authorised *(if applicable)*			**Date**
Date account created			
Date passphrase sent			

Information for New Patients: about your Summary Care Record

Dear Patient,

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outline below; please indicate your choice on the form overleaf.

- **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and for adverse reactions only.
- **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.
- **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) will be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed this consent form, please return it to your GP Practice.

You are free to change your decision at any time by informing your GP Practice.

Summary Care Record patient consent form

Having read the information regarding your choices, please choose **one** of the option below and return the completed form to your GP practice:

Yes – I would like a Summary Care Record

☐ Express consent for medication, allergies and adverse reactions only.

or

☐ Express consent for medication, allergies, adverse reactions and additional information

No – I would not like a Summary Care Record

☐ Express dissent for Summary Care Record (opt out).

Name of Patient			
Date of Birth		**Patient's Postcode**	
Surgery Name	Birtle View Medical Practice	**Surgery Location**	Heywood
NHS Number (if known)			
Signature		**Date**	

If you are filling this form out on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name	

Please circle one:

I am the:

Parent	**Legal Guardian**	**Lasting power of attorney for health and welfare**

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

For GP practice use only

To update the patients consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

Summary Care Record consent preference	Read 2	CTV3
The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only	9Ndm.	XaXbY
The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	9Ndn.	XaXbZ
The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out)	9Ndo	XaXj6