1.Have you ever registered with us before? No □ Yes □	GMS1 TOPCLIFFE SURGERY MEDICAL REGISTRATION FORM	OFFICE USE ONLY EMIS ID: Initials & Date:

Please complete ALL THREE SIDES of this form in BLOCK CAPITALS and tick □ as appropriate. IF YOU WOULD LIKE THIS FORM IN AN ALTERNATIVE FORMAT, FOR EXAMPLE LARGE PRINT OR EASY READ, OR IF YOU NEED HELP WITH COMMUNICATION WITH US, FOR EXAMPLE BECAUSE YOU USE BRITISH SIGN LANGUAGE, PLEASE LET US KNOW. PLEASE SPEAK TO THE RECEPTIONIST OR YOU CAN CALL US ON: (01845) 577297.

2.Sex: Male □ Female □	3. Title: Mr □ Mrs □ Miss □ Ms □ Other □

4.Family name (surname):

5.First name: Middle names(s):

6.Date of birth: day: month: year:	7.NHS number (if known):

8. Marital status: Single □ Married □ (previous surname(s):)

9.Town & Country of Birth:	10. First language: □ English □ Other please specify:

11. Current Address:

House Name or number: _____ Street: _____

Town/City: _____ County: _____ Postcode: _____

Tel No. (Home): _____ Tel No. (Mobile): _____ _____

Email: _____ Please go to question 12.

OFFICE USE ONLY – TO BE RECORDED IN EMIS
□ Dispensing patient: Yes/No (Ensure EMIS registration is correct)

12. Please help us trace your previous medical records by providing the following information:
Your previous address in the UK:
House Name or number: _____

Street: _____ Town/City: _____

County: _____ Postcode: _____

Name of previous doctor while at this address: _____

Address of previous doctor: _____

13. If you are registering a child under 5:
□ I wish the child above to be registered with the doctor named overleaf for Child Health surveillance

14. Please note: The surgery can dispense medication to most patients. If you need your doctor to dispense medicines and appliances please tick one of the following as appropriate:

□ I live more than 1 mile in a straight line from the nearest chemist
□ I would have serious difficulty in getting them from a chemist

AS PART OF THE REGISTRATION PROCESS, YOU WILL BE ALLOCATED A NAMED GP WHO WILL HAVE OVERALL RESPONSIBILITY FOR THE CARE AND SUPPORT THAT OUR SURGERY PROVIDES TO YOU. THIS DOES NOT PREVENT YOU FROM SEEING ANY GP IN THE PRACTICE. THE RECEPTIONIST WILL TELL YOU WHO YOUR NAMED GP IS.

P.T.O.

15. NHS Organ Donation:
If you would like to register as an organ or blood donor, please do one of the following:
Visit www.organdonation.nhs.uk or www.blood.co.uk
Or telephone 0300 123 23 23

If you have recently moved to the UK from abroad, or you are returning from the Armed Forces, please complete question 16 or 17. Otherwise please go straight to question 18.

16. If you are from abroad:

Your first UK address where registered with a GP: _____

_____

If previously resident/registered in the UK, date of leaving: _____

Date you first came to live in UK: _____

17. If you are returning from the Armed Forces:

Address before enlisting: _____

Service or Personnel number: _____ Enlistment date: _____

Leaving Date: _____

We will also need a copy of your Fmed133 Medical History on release from HM Forces Form. Please enclose with this completed form.

If you have ever been a member of the Armed Forces please tick here: □

18. Ethnicity. Please tick to indicate which ethnic group you most closely identify:

White:	Asian:	Mixed:
□ White British (9i0)	□ Asian Indian (9i7)	□ White & Black Caribbean (9i3)
□ White Irish (9i1)	□ Asian Pakistani (9i8)	□ White & Black African (9i4)
□ White Other (9i2)	□ Asian Bangladeshi (9i9)	□ White and Asian (9i5)
	□ Asian other (9iA)	□ Other mixed (9i6)
Chinese:	Black:	Other:
□ Chinese (9iE)	□ Black Caribbean (9iB)	□ Other ethnic group (9iF)
	□ Black African (9iC)	□ Decline to say (9iG)
	□ Black Other (9iD)	

19. Patient signature □ or Signature on behalf of patient □ (please tick as appropriate)

Signature: …… Date: ……

OFFICE USE ONLY TO BE RECORDED IN EMIS
Identity documents seen:
□ Passport □ Driving Licence □ Bank/Bsociety statement □ Utility Bill □ Other(please state): ……..
□ Named GP allocated □ Named GP informed □ TOP Health status template completed for I&C needs
□ Patient alert added for patients with I&C needs □ Patient coded for History relating to Military Service

HA use only Patient registered for: □ GMS □ CHS □ Dispensing □ Rural Practice

IF YOU ARE NOT ORDINARILY RESIDENT IN THE UK PLEASE COMPLETE PAGE 3 OF THIS FORM

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 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 e.g. 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 non-UK EHIC or PRC?	**YES: □** **No: □**	If yes, please enter details from your EHIC or PRC below:
	Country Code:	
	Name:	
	Given Names:	
	Date of Birth:	DD MM YYYY
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	Personal Identification Number:	
	Identification number of the institution:	
	Identification number of the card:	
	Expiry Date:	DD MM YYYY

PRC validity period	(a) from:	DD MM YYYY	(b) 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 if 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.

To be completed by the doctor:

Doctors Name: …….. HA Code: ……

□ I have accepted this patient for general medical services □ For the provision of contraceptive services

□ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name: *If different from above* …….. HA Code: ……

□ I am on the HA CHS list and will provide Child Health Surveillance to this patient **or**

□ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name: *If different from above* …….. HA Code: ……

□ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

□ I am claiming rural practice payment for this patient

Distance in miles between my patient's home address and my main surgery is: ……

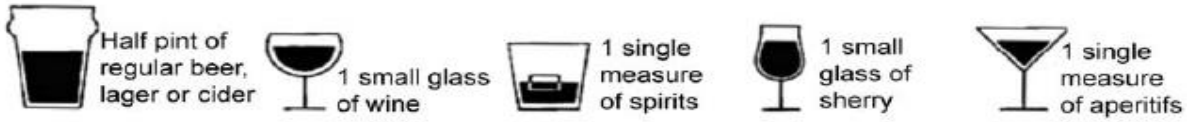
I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission *Authorised Signature:* *Name:…… Date: ……*	*Practice Stamp*

TOPCLIFFE SURGERY NEW PATIENT QUESTIONNAIRE

1. Name:
2. Date of birth: day: month: year:
3. Height: _____ (cms/meters/feet & inches)*
4. Weight: _____(Kilograms/Stones & pounds)*
5. Smoking status: □ I have never smoked
   □ I am a current smoker and smoke (please tick all that apply):
   A: □ A pipe B: □ cigars C: □ roll my own cigarettes D: □ Purchased cigarettes
   E: _____ (amount per day) Please contact Smoke Free Life on: 0800 2465215/01609 663023
   □ I am an ex-smoker and smoked (please tick all that apply):
   A: □ A pipe B: □ cigars C: □ roll my own cigarettes D: □ Purchased cigarettes
   E: _____ (amount per day)
   Stopped when? _____ How many years did you smoke? _____
   We strongly advise everyone to stop smoking. If you would like help to stop, please ask at reception.

6. ALCOHOL CONSUMPTION IN UNITS:
   In an average week, how many units of alcohol do you drink? _____ (write 0 if you do not drink)

   GUIDE TO ALCOHOL UNITS
   This is one unit of alcohol…



   …..and each of these is more than one unit

7. If you answered 0 to Q6, please skip Q7 and go straight to Q8. If you answered 1 or more to Q6, please complete Q7:

ALCOHOL STUDY	SCORE 0	SCORE 1	SCORE 2	SCORE 3	SCORE 4	YOUR SCORE
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 to 3 times per week	4+ times per week	
How many UNITS of alcohol do you drink on an average day when you are drinking?	1 to 2	3 to 4	5 to 6	7 or 8	10+	
How often do you have 6 or more units of alcohol on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the past year you have found you could not stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the past year have you failed to do what was expected of you because of alcohol?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the past 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 past 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 past 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 you know been injured as a result of 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 reduce?	No	-	Yes, but not in the last year	-	Yes, during the last year	
Alcohol questionnaire adapted from the Word Health organisation collaborative study developed by the University of Sydney, Australia.				Please write your total score here:		

Have you scored 15 or above on the alcohol study? No: □ Yes: □
If yes, your drinking is considered harmful. Please see the doctor or nurse to discuss this further.

PLEASE HELP US TO HELP YOU! IF YOU ARE ON ANY MEDICATION, HAVE ANY OF THE PROBLEMS LISTED BELOW OR OTHER HEALTH CONCERNS, THEN PLEASE MAKE AN APPOINTMENT TO SEE THE DOCTOR

8. Do you look after someone? No: □ Yes: □
   Who do you care for: _____
   Your relationship to them: _____

9. Do you have a carer? No: □ Yes: □
   Your carer's name: _____
   Their contact tel no:_____
   Their relationship to you: _____

10. Exercise: In an average week, how often do you take exercise which leaves you mildly out of breath, and makes you sweat slightly?
    A: □ never B: □ once a week C: □ twice a week D: □ 3+ times a week
    Office use: E: □ inadequate amount F: □ health ed.

11. Do you have any of the following:

	YES	NO		YES	NO
Heart disease, Heart Attack or Stroke			Eczema or hay fever		
High Blood Pressure			Arthritis		
Diabetes			Epilepsy		
Chronic pulmonary obstructive disease			Thyroid condition		
Asthma			Mental health problem		
Do you use an inhaler every day			Cancer		
Other (please specify)			Inflammatory bowel disease		

We would like to provide you with the best possible care. If you have any information & communication needs (eg. You need an interpreter, large print or easy read, braille or British sign language) please indicate below:

INFORMATION & COMMUNICATION NEEDS CATEGORY	SPECIFIC NEEDS
Hearing Difficulties	
Sight Difficulties	
Language Difficulties/English not first language	
Literacy Difficulties	
Learning disabilities	

Please give us permission to share information regarding these needs with other NHS and adult care providers as required: □

12. Family History
    Does your parent, brother, sister or child have any problem such as: ovarian or bowel cancer, osteoporosis, heart disease or strokes, diabetes, high blood pressure or cholesterol? If so please fill in the table below:

DISEASE	RELATION	AGE AT ONSET	DETAILS

**Please delete as appropriate*

13. MEDICINES: Please indicate if you are on any medication including tablets, creams, inhalers, contraception:
    No: □ Yes: □
    If you are on any medication, please make an appointment to see the doctor with a list of your current treatment before you need some more.

14. ALLERGIES OR REACTIONS: Please give details of any allergic reactions you may have for example to : eggs, medications, vaccinations, medical dressings or foodstuffs:
    _____

15. Have you ever had an NHS Health Check? No: □ Yes: □ (Date of your most recent test: _____)

16. Do you have a living will? No: □ Yes: □ If yes, please may we have a copy?

PLEASE ENSURE THAT YOU HAVE COMPLETED <u>BOTH</u> SIDES OF THIS QUESTIONNAIRE BEFORE RETURNING THIS FORM TO RECEPTION