

Please complete all sections of the form in CAPITAL LETTERS otherwise it may result in a delay of your registration

DE MONTFORT SURGERY PATIENT REGISTRATION FORM

NHS Number:

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Previously Registered at De Montfort Surgery?

Yes
 No

Gender: Male
 Female
 Non - binary

Title: Mr / Mrs / Miss / Ms / Dr / Prof /
Other

Are you Student
a Non Student

De Montfort Uni
 Leicester Uni
 Other

Surname:

Previous Surname (As it appears on your passport):

First Name:

Country and Town of Birth:

Middle Names:

Date of Birth (DD/MM/YYYY):

Leicester Address: (Include Flat Number, Room Number, Block Number
and House name i.e. Room 206, Flat 7, Block G Nixon Court)

Mobile:

Home Telephone:

Email:

Post Code:

Please help us trace your previous medical records by providing the following information

Previous UK Address:

Name and address of Registered GP whilst at your previous
address:

Date you first came to live in UK:

If previously a resident in the UK, date of leaving:

I confirm that I am **PERMANENTLY** living in Leicester or I am in Leicester until __ / __ / __

Next of Kin
Details

Name:

Relationship:

Telephone:

**By completing this section you
are giving consent for us to
contact the named person in
an emergency**

Have you ever been employed within the Armed Forces? Yes No

Personnel Number:

Date Enlisted:

Date Left:

Do you suffer from any existing medical conditions?

Significant Past Medical/Mental Health History:

Are you on any current medication?

Family Medical History (please state family member
and condition.)

Any known allergies (please specify)

**If you have a Nominated pharmacy this will now need amending prior
to making a new request for medication**

**In order to continue to receive your repeat medications you'll need to make an appointment with the practice
pharmacist at least one week before your next prescription is due.**

TB Information		Vaccination Information	
Are you aged between 16-35 years	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had your Meningitis ACWY vaccination?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Have you previously tested or treated for TB	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you lived in England for less than 5 years	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had all of your MMR vaccinations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Have you ever lived in a high incidence country for 6 or more months	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please specify:			

Do you have a Disability? Yes No
 If yes, please tell us how we can support your needs:

Do you have a communication need that is related to a disability, impairment or sensory loss? Yes No
 If you have answered yes, please specify:

Do you require information in a preferred format? Yes No
 If Yes, please specify:

What is your ethnic group? (Choose an option that best describes your ethnic group or background)

White	<input type="checkbox"/> British	<input type="checkbox"/> Irish	<input type="checkbox"/> Other (Please specify):
Black	<input type="checkbox"/> Caribbean	<input type="checkbox"/> African	<input type="checkbox"/> Other (Please specify):
Asian	<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Other (Please specify):
Mixed	<input type="checkbox"/> White/Black Caribbean	<input type="checkbox"/> I do not wish to answer	

Main spoken languages English Other (please specify)
 Interpreter required? Yes No

Which of the following best describes you?

<input type="checkbox"/> Heterosexual (Straight)	<input type="checkbox"/> Male homosexual (Gay)	<input type="checkbox"/> Transgender gender reassignment patient
<input type="checkbox"/> Bisexual	<input type="checkbox"/> Female homosexual (Lesbian)	<input type="checkbox"/> Transgender gender identity disorder

Are you a Carer? Yes by profession Yes, for a family member or friend
 If yes, do you look after someone who is a patient of De Montfort Surgery? Yes No
 Their name:

Do you have a Carer? Yes No
 If Yes, Their name and contact details:

Looked after Children *Please note you have a duty to notify social care of this arrangement*













Are you a looked after child? Yes No
 If Yes, Please give the Carers Full name and contact details:

Are you looking after a child that is NOT your own? Yes No
 If Yes, Please give the Childs Full name and your relationship to them:

LIFESTYLE INFO

Height:	Exercise: <input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> 3 times a week <input type="checkbox"/> 4+ times a week <input type="checkbox"/> Competitive Athlete	Smoking Status: <input type="checkbox"/> Never smoked <input type="checkbox"/> Ex-Smoker Date stopped: <input type="checkbox"/> Social Smoker <input type="checkbox"/> Smoker <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigar <input type="checkbox"/> Pipe <input type="checkbox"/> VAPE <input type="checkbox"/> Would you like advice on quitting?
Weight:		

Please tell us about your alcohol consumption (Please see over for alcoholic units guide)

1 UNIT	1.5 UNITS	2 UNITS	3 UNITS	9 UNITS	30 UNITS
 Normal beer half pint (284ml) 4%	 Small glass of wine (125ml) 12.5%	 Strong beer half pint (284ml) 6.5%	 Strong beer Large bottle/can (440ml) 6.5%	 Bottle of wine (750ml) 12.5%	 Bottle of spirits (750ml) 40%
 Single spirit shot (25ml) 40%	 Alcopops bottle (275ml) 5.5%	 Normal beer Large bottle/can (440ml) 4.5%	 Large glass of wine (250ml) 12.5%	Government advises alcohol consumption should not regularly exceed:  Men 3-4 units daily  Women 2-3 units daily	

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Questions (please tick your answers)	Unit Scoring System				
	0	1	2	3	4
How often do you have a drink containing alcohol?	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly or less	<input type="checkbox"/> 2-4 times per month	<input type="checkbox"/> 2-3 times per week	<input type="checkbox"/> 4+ times per week
How many units of alcohol do you drink on a typical day when you are drinking?	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5-6	<input type="checkbox"/> 7-9	<input type="checkbox"/> 10+
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	<input type="checkbox"/> Never	<input type="checkbox"/> Less than monthly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily or almost daily

Depending on your answers above you may be asked to complete an additional alcohol questionnaire.

Females Only

Date of last Smear and result: (If known)

Contraception Used:

Communication Preferences

Do you consent to receive the following types of communication from De Montfort Surgery?

Email Yes No Mobile phone text messages Yes No

GP Online Services – Patient Online Access

Once your application to join our practice has been accepted you will be able to order your repeat medications, book appointments and view certain aspects of your medical record via the internet. This service is known as **Patient Access**.

If you would like to arrange your Patient Access please ask for an Online Access Form. This will need to be completed fully and returned to the surgery with **one form of photo identification** (Passport / Driving Licence / Student Card)

We can only accept your request for Patient Access if your email address is valid and not shared by another person.

PATIENT RECORD SHARING

Summary Care Record (SCR)

Summary Care Records are an electronic record of patient information created from GP medical records. They can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care. It includes important information about your health: Medicines you are taking; allergies you suffer from, any bad reactions to medicines.

You can also choose to have additional information included in your SCR, which can improve the care you receive. This information 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; who should be contacted for more information about you. **More information can be found by visiting www.nhs.uk/nhsrecords**

Tick this box if you wish to **include** additional information to your SCR Tick this box if you wish to **OPT-OUT** of the SCR

Electronic Data Sharing Module (EDSM)

Healthcare places can usually share information from your records by letter, email, fax or phone but this can slow down your treatment or mean information is hard to access. However you can choose to share your record electronically between many of the community health services and GP practices in Leicester, Leicestershire & Rutland. For more information please visit our website www.demontfortsurgery.co.uk

Do you consent for us to **SHARE** your record with other services that might care for you

Do you consent for us to **VIEW** your data recorded at other care services that might care for you

NHS Organ Donor Registration

I would like to join the NHS organ donor register as someone whose organs may be used for transplantation after my death

(Please tick)

- Any of my organs and tissue or...
 Kidneys Heart Liver Corneas
 Lungs Pancreas Any Body Part

Please note that it is your responsibility to ensure your contact details are correct and you acknowledge this by signing this application form to register with De Montfort Surgery.

Signature:

Date:

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 / YYYY
*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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please enter details from your EHIC or PRC below:
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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.

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	(b) To: DD / MM / YYYY
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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.

If there are any problems with your registration we'll contact you to clarify any issues.

Please record any additional information about you that you think is important for us to know

*Signed	*Date DD / MM / YYYY
*Signed on behalf of patient (if applicable) (e.g. for minors under 16 years old, adults lacking capacity)	