DR KILLY & PARTNERS

TELEPHONE - 01376 337272

PLEASE DO NOT BRING REGISTRATION FORMS BACK DURING OUR BUSY PERIOD 11:30AM – 2:30PM

PLEASE READ CAREFULLY BEFORE FILLING IN THE FORMS

Registration forms must be completed in **FULL**

You will need to bring in **(Two)** different forms of ID (Original copies only) and your NHS number

1) Proof of Address

(e.g Tenancy Agreement, Utility Bill or Bank Statement)

2) Photographic I.D

(e.g Passport, Drivers Licence or Bus Pass)

AND

3) NHS Number

(This can be found by contacting your previous surgery)

PLEASE NOTE – WE ONLY ACCEPT NEW PATIENTS THAT LIVE WITHIN THE **CM8** POSTCODE

OPENING HOURS

MON – FRI 08:00 – 18:00

Telephone lines are open until 18:30

WE SUPPORT THE NHS ZERO TOLERANCE CAMPAIGN

PLEASE MAKE SURE YOU FILL IN ALL REQUESTED INFORMATION AND SIGN ALL FORMS. WITHOUT THIS WE WILL BE UNABLE TO REGISTER YOU

NEW PATIENT QUESTIONNAIRE

When you have completed this form please hand in to reception with required documents. The information will be held in your personal records which like all NHS records, remain confidential.

PERSONAL DETAILS (PLEASE USE CAPITALS)

Title Mr Mrs Miss Ms Other_____

Surname_____ First Name_____

Address_____ Gender M F

_____Postcode_____

Mobile_____ Home_____

Preferred Contact _____ Other contact _____

Email address _____

Date of Birth _____ Place of Birth _____

Occupation _____

Please specify your first language _____

If English is not your first language, do you speak English? Yes No

Ethnicity _____

Do you care for someone who is frail ill disabled or mentally ill? Yes No

Are you looked after or supported because you are frail, disabled or mentally ill? Yes No

Do you have communication difficulties? Yes No

Please give your approximate weight_____height_____

SMOKING

Smoker_____ Never Smoked _____ Non-Smoker (Approx Date Quit)_____

If smoker, how many on average per day_____ How long have you smoked for_____

Do you wish to stop smoking? Yes No

CURRENT MEDICATION

Please attach a copy of your current medication from your previous GP and ensure you have enough to

last you at least 4 weeks as it can take time for your notes to come across and for the surgery to set up your repeat prescription.

Please confirm which pharmacy you would like your prescriptions to go to if you do not do this we will nominate one on your behalf as all prescription are now ETP (Prescribed Electronically)_____

ALLERGIES

Please list any allergies you may have such as medication, animals, pollen, nuts, hayfever etc

Have you ever had an adverse reaction Yes No

NEXT OF KIN

Next of Kin _____ Relationship to you _____

Contact Number_____

PLEASE NOTE, NEXT OF KIN **DOES NOT** GIVE THEM PERMISSION TO ACCESS / DISCUSS YOUR MEDICAL RECORDS OR RESULTS ETC – IF YOU WOULD LIKE THIS FACILITY, PLEASE REQUEST A CONSENT FORM AT RECEPTION

Please sign if you agree to share your record with relevant third parties (this includes hospital, walk in centre, AED and other surgeries if seen there)

I agree to share information with third parties if needed

All information listed on this registration (Inc your Next of Kin) will be recorded within your medical records

Signature:

AS A NEW PATIENT WE WOULD LIKE YOU TO CALL AND BOOK AN APPOINTMENT WITH THE HCA FOR A HEALTH CHECK WHICH INCLUDES A FASTING BLOOD TEST. YOU CAN CALL AND BOOK THIS APPROX 1 WEEK AFTER REGISTERING. WE LOOK FORWARD TO SEEING YOU

New Patient Questionnaire

systmonline

BOOK REQUEST REGISTER

PLEASE NOTE – Due to increasing changes within the NHS, we request that all new patients complete this form; you will be able to book appointments, request repeat prescriptions and access your medical records online.

Please tick one of the following whether you would like us to:

Print out your log in details for you to collect from reception ☐

Send your log in details by SMS message ☐

Send your log in details by email ☐

Signature: _____ Date:

For Practice Use Only

Identity verified through: Vouching ☐ Date Verified:_____

Vouching with information in record ☐

Photo ID ☐

Proof of residence ☐

Name of person who authorised (if applicable) _____

Date account created and log in details sent:

Dr Killy & Partners

PATIENT'S AGREEMENT

On joining Dr Killy & Partners at the Witham Health Centre I have read and agree to the following :-

- I understand that by not turning up for appointments, I am denying patients who are unwell and need to be seen the opportunity of being offered an appointment. I will therefore inform the surgery if I am unable to attend an appointment.

- I must be prepared to see a nurse instead of a doctor for minor illness, or when advised that this is appropriate. (Please note our nurses are skilled and an essential part of our patient care team, helping free up the doctors' time for patients with more complex problems).

- I accept and understand that the length of a routine appointment with the Doctor is 10 minutes. We try to keep to appointments times, but sometimes one patient may need more time and you may have to wait a little longer. It maybe you who needs some extra time so please bear with us. You can also request a double appointment if you wish to discuss more than one matter with the GP. If you inform reception when booking the appointment, it ensures that we as a practice can allocate accordingly to your needs.

- I accept and understand that I will not be abusive towards the reception/administration staff. It is with regret that we now ask ALL patients to agree not to be abusive to any of our staff. We find this kind of behaviour is increasing. The surgery has a policy of ZERO TOLERANCE and therefore will REMOVE any such patient from our practice list should they breach our policy.

I understand and agree to the above policy:-

PRINT NAME ……

SIGNATURE …….

DATE ……..

If you have any concerns regarding the above please ask to speak to the Practice Manager.

Thank you.

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ARE YOU A CARER

If you are looking after a relative or friend who is elderly or has an illness, including mental health problems, or a disability, you <u>are</u> a carer.
Or
If you are looking after a child who has an illness or learning difficulties, you <u>are</u> a carer.

This surgery values carers and is working with Action for Family Carers across Essex to support you in your caring role. If you are a carer, please fill in your details below and hand the form into reception.

Carer

Name:
Address:
Telephone No:
E-mail address:

Details of Person cared for

Name:
Address:
Telephone No: (if different from above)
Relationship to Carer:

Consent of Carer

I consent to the above details regarding my Carer status being recorded in my medical records. Signature: Date:

Consent of Person Cared For

I consent to the disclosure by The Witham Health Centre of such clinical information as may be considered necessary by the doctor to the carer named above. Signature: Date:

Name of GP:

…….

Surgery use only

	Initials	*Date*
Entered into Carer's notes - Ub1ju		
Entered onto notes of person Cared for - .918F		
Consent entered in both patients' notes if relevant		

Action for Family Carers supporting Carers across Essex are a Carers Trust Network Partner and Centre of Excellence, they hold a PQASSO level 3, NCVO's highest quality mark for charity management and governance and they provide support and advice to carers.

A Carer which contacts Action for Family Carers supporting Carers across Essex can:

- Receive information on their rights
- Information on financial and legal matters
- Explaining power of attorney
- Support to access grant funding
- Helping you plan for an emergency
- Respite day care across the county
- Offer free, confidential counselling service
- Telephone befriending

Please tick the appropriate box if you would like:

- The surgery to pass your details on to the Action for Family Carers ☐
- A support worker from Action for Family Carers to telephone you ☐

NHS Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☐ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ 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

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*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1.6km in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

☐ **Signature of Patient** ☐ **Signature on behalf of patient**

Date_____/_____/_____

What is your ethnic group?

Please tick one box that best describes your ethnic group or background from the options below:

White: ☐ British ☐ Irish ☐ Irish Traveller ☐ Traveller ☐ Gypsy/Romany ☐ Polish
☐ Any other white background (please write in):

Mixed: ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian
☐ Any other Mixed background (please write in):

Asian or Asian British: ☐ Indian ☐ Pakistani ☐ Bangladeshi
☐ Any other Asian background (please write in):

Black or Black British: ☐ Caribbean ☐ African ☐ Somali ☐ Nigerian
☐ Any other Black background (please write in):

Other ethnic group: ☐ Chinese ☐ Filipino
☐ Any other ethnic group (please write in):

Not stated: ☐
Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

062021_006 Product Code: **GMS1**

NHS Family doctor services registration

GMS1

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 an EU 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:
 *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

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 Business Service Authority for the purpose of recovering your NHS costs from your home country.