Bewicke Medical Centre

51 Tynemouth Road, Howdon, Wallsend , NE28 0AD

Tel: 0191 2623036, Web: www.bewickemedicalcentre.nhs.uk

Emis No.:

Thank you for applying to join Bewicke Medical Centre. We would like to gather some information about you and ask that you fill in the following questionnaire. **You may need to supply TWO forms of Identification with your completed form, a photographic form of ID (such as a PASSPORT or DRIVING LICENCE) and proof of your home address (such as a recent BANK STATEMENT or UTILITY BILL).**

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Please ensure you **SIGN** and **DATE** your form.

***\*\*YOU ARE REQUIRED TO FILL IN THE FIELDS MARKED WITH AN ASTERISK (\*), FAILURE TO DO SO MAY DELAY YOUR REGISTRATION\*\****

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **\***Title: | \*Surname: |  | **\***First names: | |
| **\***Any previous surname(s) (if applicable): | |  | **\***Date of Birth: DD / MM / YYYY | |
| **\*** Male  Female  Intermediate  Unspecified | |  | **\***NHS No. | |
| Town and country of birth: | |  | **\***Home address: | |
| **\***Home telephone No.: | |
| Work telephone No.: | |  | \*Postcode: | |
| \*Mobile No. (if you have one):  \***Occupation** | |  | **Email address:** | |
| **Main Language**  Which is your main language?  Do you speak English?  Do you need an interpreter? | |  | **Specific Contact requirements.** Do you require contact in a specific format (e.g due to blindness, deafness or other impairments? If so please give details. | |
| **What is your faith / religion?**  **Do not wish to state?** | |  | **If this is for a child – please indicate which school the child attends:** | |
| **Next of Kin/ Emergency Contact :**  Name / Relationship to you / Telephone No. / Address (if different to yours)  **Are you interested in joining our Virtual Patient Group YES NO** | |  | **Contacting You:** We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your medical care.  **Give consent to receiving letters YES / NO**  **Give consent to text messages YES / NO**  **Give consent to receiving emails YES / NO**  **Give consent to leaving simple messages YES / NO** | |
| **Online Patient Access**   |  | | --- | | Online Patient Access enables you to order your repeat medications; view coded medical records and book appointments up to 4 weeks in advance.  **Please note if you providean email address we will automatically active online access and email over the login details to register to use this service. Consent to receive emails from Bewicke Medical Centr will apply unless stated opt out.**  If you require access for a child please read proxy information first. Please ask at reception |   **Do you have a learning disability?**   |  | | --- | | A significantly reduced ability to understand new or complex information and to learn new skills(Significantly impaired intelligence) **AND** A reduced ability to cope independently, (impaired social / adaptive functioning) **AND** Which started before adulthood (onset before aged 18) with a lasting effect on development  Factors such as: Delayed development/difficulties before the age of 18. Requires significant assistance to undertake daily activities.  Please state:………………………………………………………………………………………………………………………………………………………………… |   **What is your ethnic group?**   |  | | --- | | **Main spoken language (E.g. English):**  **White**  British  Irish  Other White (please specify):  **Black**  Caribbean  African  Other Black (please specify):  **Asian**  Indian  Pakistani  Chinese  Other Asian (please specify):  **Mixed**  White + Black Caribbean  White + African  White + Asian  Other mixed: |   **Please help us trace your previous medical records by providing the following information** | | | | |
| \*Previous address in the UK (if applicable):  Postcode: | |  | | Name of previous doctor: |
| Address of previous doctor: |

**Service Families and Military Veterans**

We support the Armed Forces Covenant. We can only do this if we know our patients connections to the Armed Forces. Please tick the below boxes that apply to you

|  |  |  |  |
| --- | --- | --- | --- |
| I **AM** a Military Veteran |  | **I AM** currently serving in the Reserve Forces |  |
| I **AM** married/civil partnership to a serving member of the Regular/Reserve Armed Forces |  | I **AM** married /civil partnership to a Military Veteran |  |
| I **AM** under 18 and my parent(s) are serving members o9f the armed forces |  | I **AM** under 18 and my parents are veterans of the armed forces |  |

**Please advise if you have been or are returning from the Armed Forces**

|  |  |  |
| --- | --- | --- |
| Address before enlisting:  Postcode: |  | Service or Personnel No.: |
| Enlistment date:  Date left the Armed Forces: |

**If you have been living abroad.**

|  |  |  |
| --- | --- | --- |
| \*Your first UK address where you registered with a GP if you were previously living abroad:  Postcode: |  | \*If previously a resident in the UK, date of leaving: |
| \*Date you first came to live in the UK (if applicable): |

**For female patients only**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Are you currently pregnant** | **yes** | | **No** | |  | (**for women only**) Have you had a cervical smear?  Yes  No (*Please state where, when and the result if possible*) |
| **Which method of contraception (if any are you using at present?** | |  | | |
| **Do you have a long acting reversible contraception in place? ( Implant/ Coil)** | | **YES** | | **NO** |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Resuscitations wishes and Power of Attorney**  Do you have a DNACPR ( do not attempt CPR) form in place | **YES** | **NO** |
|  | Does anybody hold Lasting Power of Attorney for Health and Welfare for you? | **YES** | **NO** |
|  | If yes to either of the above questions, please supply details of who holds this and where (and supply a copy for your medical notes) | **Details.** | |

|  |
| --- |
| **The Accessible Information Standard (AIS)**  Please tell us about any specific communication needs you have. I.e. needing information in large print or deafblind telephone contact. For further information please visit [**www.england.nhs.uk/ourwork/accessibleinfo/**](http://www.england.nhs.uk/ourwork/accessibleinfo/)  Do you have any disabilities, illnesses or accessibility needs? I.e. needing to be seen in accessible consulting rooms or use of a specific communication device such as a hearing aid? If yes, please tell us how we can support your needs:  **Communication Preferences**  By providing your contact details including your email address, mobile and home telephone number you are agreeing for the practice to communicate with you by these methods. E.g. send appointment reminders to your mobile and leave messages on your answering machine,  **Only select if you DO NOT wish to be contacted in this way**  **Email**  **SMS**  **Answering machine**  **Letter Post**  **Please note by selecting all means we are unable to contact you at all.** |

**Carers Information**

|  |
| --- |
| A carer is a friend / family member who gives their time to support a person in their home, to an extent that the person could not remain at home if this care was not being provided. A carer can receive Carers Allowance (but not a wage) and the care they are giving will significantly affect their own life*.*  **Are you looked after by someone whose support you could not manage without?**  Yes  No  If yes, what is their name and contact number?  Do you consent for your carer to be informed about your medical care?  Yes  No  **Do you look after or support someone who couldn’t manage without you?**  Yes  No  If yes, do you look after someone who is a patient of Bewicke Medical Centre?  Yes  No  Don’t know  If yes, what is their name: Are they a  Friend  Relative  Neighbour |

**Looked after Children** *(Complete this section only if you are looking after someone else’s child)*

|  |
| --- |
| Under what arrangements are you looking after someone else’s child?  Section 20-Voluntary Care  Interim Care Order  Care Order  Child arrangement order/Residence Order  Special Guardianship Order  Placed for adoption  Private arrangement/Private Fostering/informal (*please note you have a duty to notify social care of this arrangement*)  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.  **Is the child a Looked after child?** YES  NO(A child who is being looked after by their local authority (**child in care**)  **If you are applying on behalf of a child who is in**  Foster Care  Residential Care Kinship Care(looked after by a relative)  The legal parent or guardian is  The above named person can consent for medical treatment of the child.  Other named person can consent for medical treatment for the child  **please specify name and relationship** |
|  |

**Medical details**

|  |
| --- |
| In order to continue to receive **your repeat medications** you’ll need to make an appointment with a GP before your next prescription is due. **Please book the appointment following your New Registration Appointment**. |

|  |  |
| --- | --- |
| **Electronic Prescription Service (EPS)**  Nominate a pharmacy to collect your prescriptions from. EPS enables prescribers, such as GP’s and practice nurses, to send prescriptions electronically to a pharmacy of the patient’s choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.   |  | | --- | | **Please advise who is your nominated pharmacy**  **Pharmacy Name & Address:** |   **Repeat Dispensing Service**  We offer a repeat dispensing service which is a new way of getting your certain repeat medications that you use regularly. This means you won’t have to re-order or collect your repeat prescriptions from your GP practice every time you need more medication. Please ask at reception. |

|  |
| --- |
| **Allergies**  **\***Are you allergic to any medicines?  Yes  No (if yes please specify)  **\***List other allergies / intolerances (i.e pollen, animal hair or certain foods. Please mark “none” if you have no other allergies that you know of): |

**Patient History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Do You have diabetes?** | YES | NO | (If yes please register patient with Dr Cooke or Dr Petrie) |

|  |
| --- |
| List any serious illnesses / operations / accidents / disabilities (women: any pregnancy related problems) & the year they took place: |

|  |
| --- |
| **MENINGITIS ACWY IMMUNISATION**  NHS England strongly recommends anyone who is aged between 18-24yrs to have an ACWY booster if you haven’t already done so.  Yes, I would like a booster (if you tick this please ask to book an appointment following your registration appointment)  No, I would not like a booster  I have already had a Men ACWY booster on (date):…………………………………… |

**Data Sharing**

|  |
| --- |
| **Summary Care Record (SCR)**  The Core SCR includes important information about your health: Medicines you are taking, allergies you suffer from and 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 and who should be contacted for more information about you.  You may need to be treated by health and care professionals outside of the practice who do not know your medical history. Having the additional information SCR can help the staff involved in your care access information more quickly,  allowing them to make informed decisions about your healthcare. More information can be found by visiting [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk)  Tick which box you wish to apply  Opt-in to the **Core SCR**  or Opt-in to the **Core and Additional SCR**  To opt-out of the **SCR**  If you choose to opt-out of sharing your confidential patient information for research and planning you should go to “Your NHS Data Matters” website([www.nhs.uk/your-nhs-data-matters](http://www.nhs.uk/your-nhs-data-matters)) or contact 0300 303 5678  If you **do nothing** we will automatically create a Summary Care Record. Children under 16 will automatically have a Summary Care Record created unless their parent or guardian chooses to opt them out. If you feel that the child is old enough to understand, then you should make this information available to them. For more information talk to our Patient Advice and Liaison Service (PALS) (0800 0320202) or visit [northynepals@nhct.nhs.uk](mailto:northynepals@nhct.nhs.uk) |

|  |
| --- |
| **Donor Registration Choices- The Law has now changed Organ Donation in England has moved to an “Opt Out system” Make your decision via https://www.organdonation.nhs.uk/uk-laws/organ-donation-law-in-england/** |

|  |
| --- |
| **NHS Blood Donor Registration**  I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.  Yes I give consent to be included on the NHS Blood Donor Register  Tick here if you have given blood in the last 3 years  Signature confirming consent to inclusive on the NHS Blood Register. My preferred address for donation is: (only if different from above, e.g. your place of work)  ……………………………………………………………………………………………………………………………………. Postcode: ……………………………………………………… |

|  |  |  |
| --- | --- | --- |
| **\*Signed** |  | **\*Date** DD / MM / YYYY |

|  |
| --- |
| **Signed on behalf of patient** (*if applicable*)  (e.g. for adults lacking capacity) |

|  |
| --- |
| **Proof of Identity and Address:** **PHOTO ID TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(Aged 18 and over only)  Birth Certificate  Allowance Book  Driving Licence  Tenancy Agreement Passport  Utility Bill  Other Please state:  **Check by Staff Initials** |

|  |  |  |
| --- | --- | --- |
| **Doctor Name** |  | Authorised Signature |

To be completed by the Doctor

|  |  |  |  |
| --- | --- | --- | --- |
| **SUPPLEMENTARY QUESTIONS** | | | |
| **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?** | 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 The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country. | | | |

|  |
| --- |
| **Please record any additional information about you that you think is important for us to know record the information below.** |

Shared Resources\Admin\Patient Forms\Bewicke Medical Centre Patient Reg Form.docx

Reception v5/ May 2021