GREENSIDE REGISTRATION FORM

Date Registered	Receptionist	NPHC booked

Title: _____ Surname: _____

Previous Surname: _____

Date of Birth: _____ Forename: _____

Country of Birth: _____ Do you have a UK Passport? Yes / No

Address: _____

_____

Post Code: _____ Home Telephone No:_____

Mobile No: _____ Work No: _____

NHS NO: _____ Email Address:_____

Your previous address: Previous GP- Doctors Name and Address:

_____ _____

_____ _____

_____ _____

Ethnicity: White British [ ] Black British [ ] Black Caribbean [ ] Black African [ ] European [ ] Asian [ ] - Please state _____ Other ethnic group (please state) _____

First language: _____ Second language (if applicable): _____

If from abroad:

Date you first came to live in the UK: Date_____ Month_____Year _____

Do you have a visa (if so please state which)

Refugee [ ] Asylum Seeker [ ] Work [ ] Student [ ] Spouse [ ]

Dates Valid from _____ and to _____

Please inform us of any pre-existing health conditions that you may need support, advice or treatment for, such as pregnancy, diabetes, heart problems, asthma etc? If pregnant please state how many weeks.

_____

Summary Care Records:

- **Do you wish to opt in for medication, allergies, adverse reactions [ ]**
- **Do you wish to opt in for medication, allergies, adverse reactions and additional information (ie., medical history) [ ]**
- **or op-out [ ]**

If none of the boxes are ticked it will be assumed that implied consent has been given

Name of Next of Kin in the UK: _____

Relationship to you: _____ Contact tel no: _____

Is your Next of Kin Registered Here? Yes / No, if Yes please give Date of Birth: _____

If you are a carer for a relative or friend please indicate who you care for: _____

Please sign: _____ Date: _____

Patient/Practice Agreement

Disclosure
I the patient named below agree to disclose all material facts regarding my health to my General Practitioner and clinical staff. We the Practice declare that we shall not disclose any information regarding the patient without the patient's written consent.

Confidentiality
We the Practice declare that we shall hold confidential all matters pertaining to the patient and not release such information without the patient's written consent.

Appointments
I agree to attend on time for all appointments that I book with the Practice and to cancel in advance any appointment I cannot attend. I acknowledge that should I arrive late for an appointment I may be asked to rebook for another time. I understand the practice has a policy for non-attendance of appointments which can result in being removed from the list.

Home Visits
I shall only request a home visit from the Practice when I cannot physically attend the surgery. I will endeavour to make this request no later than 11am.

Out of Hours Service
I agree to use the out of hours service only when medically necessary, otherwise I will wait until the surgery reopens to consult a doctor.

Emergency Consultations
I understand that an emergency consultation is only for treatment of a clinical emergency which cannot wait until the next available appointment and that routine matters cannot be dealt with in an emergency appointment.

Mobile Phones
I agree to switch off my mobile phone before entering the Practice and to keep it switched off at all times while I am in the surgery building. If I forget to switch it off I agree to switch it off immediately if it rings.

Repeat Prescriptions
If my doctor has agreed to issue repeat prescriptions I agree to give 2 working days notice. I agree to make the request by using the prescription counterfoil. I can make the request by post, fax, website or in person. I acknowledge that requests cannot be made by phone

Treatment of Staff
I agree with the policy of zero tolerance of abuse towards all NHS staff and I agree not to behave in an abusive, threatening or otherwise aggressive manner to staff at the surgery.

Food/Drink
I agree that in the interest of other patients it is unacceptable to consume food and drink within the practice building and I agree to observe this requirement at all times.

The Practice thank you for signing this agreement

Patient Name:

Signature: **Date:**