NHS **THE HOLLIES SURGERY**

41 Rectory Road, Hadleigh, Benfleet, Essex, SS7 2NA

New Patient Registration Form (Adult 16 and over)

1. Complete a separate form for each family member to be registered
2. Complete in BLOCK CAPITALS and tick the boxes as appropriate (ineligible forms will be returned)

About You				
FORENAME (including middle name):			SURNAME:	
TITLE:	GENDER:		DATE OF BIRTH:	
ADDRESS: POSTCODE:			MOBILE NUM: LANDLINE: EMAIL:	
PLACE OF BIRTH:			PREFERRED METHOD OF CONTACT:	
NEXT OF KIN FULL NAME: ADDRESS: TEL NUMBER:				
Are you currently homeless? YES □ NO □		Homeless □ Refugee □ Asylum Seeker □		

Looking After a Family Member	
Let us know if you are looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.	YES □ NO □
Let us know if a family member, friend or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice.	YES □ NO □

CARERS NAME:	RELATIONSHIP:
CONTACT NUMBER:	IS YOUR CARER RESGISTERED WITH US?
ADDRESS:	

Employment	
Are you currently employed? YES □ NO □	If you are not employed, please indicate which best describes you: Retired □ Student □ Housewife/Husband □ Unemployed □
Please specify: Full time □ Part time □ Self-employed □ Other □ *please state:*	
If returning from the Armed Forces, please state which below: □ Army □ Royal Navy □ Royal Air Force	

Ethnicity and Disabilities			
Your Ethnic Code *(please tick)*			
Black Caribbean/British □	Indian / British Indian □	Chinese/British Chinese □	White (UK) □
Black African /British □	Pakistani British Pakistani □	Vietnamese/British Vietnamese □	White (Irish) □
Other Black Background □	Bangladeshi / British Bangladeshi □	Other Asian □	White (Other) □
Other Mixed Background □	Arabic/British Arabic □		Ethnic Category Refused□
Do you consider your self to have a disability? YES □ NO □ Prefer not to say □ If yes, what disabilities do you have?			
Are you able to administer your own medications? YES □ NO □ If no give details *(e.g swallowing/opening containers):*			

Do you need help with mobility/hearing/speaking? (tick all that apply)			
Wheelchair □	Walking Air□	Hearing Air□	BSL (British Sign Language) □
Lip Reading □	Large Print□	Braille□	Other:
Do you use an assistance dog? YES □ NO □		Are you housebound? YES □ NO □	
Do you need an Interpreter? YES □ NO □ (If yes please tick)			

Punjabi □	Hindi □	Urdu □	Bengali □	Polish □
Arabic □	Farsi □	French □	Portuguese □	Spanish □
Gujrati □	German □	Other Language please specify:		

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Your Medical Background

Are there any serious diseases that affect your parents, brothers or sisters? Tick all that apply *and* state family member:

Diabetes □ Who?	Asthma □ Who?	Thyroid Disorder □ Who?	Stroke □ Who?	COPD □ Who?
Heart Attack under age 60 □ Who?	Cancer □ Who? Type:	High Blood Pressure □ Who?	Mental Health □ Who? Type:	Any other illness in the family please specify:

Please state any allergies and sensitivities to medicines and foods:

Please state your medical conditions:

What operations have you had? (dates):

What injuries have you had? (date):

Please list any tablets, medicines or other treatments you are currently taking:

Lifestyle

Smoker	*Alcohol*	*Height & Weight*	*Exercise*
YES □ How many a day: Cigarettes □ Cigars □ Vapes □ Tobacco □ NO □ Ex-Smoker □	Teetotal □ Occasional □ Heavy □ How many units per day:	Inches and Feet: CM: Weight: Kilo: Stones:	Sedentary □ (none) Gentle □ (walking ect) Moderate □ (cycling ect) Vigorous □ (Gym regular)

Sharing Your Medical Record

Medical Record Sharing allows your complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your shared medical record.
If you don't want to share your GP record tick here □

Summary Care Record contains details of your key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your Summary Care Record.
If you don't want to have a Summary Care Record tick here □

The Care. Data Programme Collates information about you and the care you receive. It links information from all the different places where you receive care, such as your GP, hospital and community services, to help them provide a full picture of your medical needs and the care you are receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes.
I wish to OPT OUT from my Personal Confidential Data being shared outside my *GP practice* □
I wish to OPT OUT from my Personal Confidential Data being shared with *third parties* □

Patient Participation Group (PPG)

The Practice is committed to improving the services we provide to our patients

- To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better
- By expressing your interest, you will be helping us to plan ways of involving patients that suit you
- It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice
- If you are interested in getting involved in the PPG, please tick yes in the box below and we will arrange for the Practice for the Practice Patient Participation Group Application Form to be given to you at your initial consultation

□ ***Yes,*** I am interested in becoming involved in the PPG □ ***No,*** I am not interested in becoming involved in the PPG

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Women Only	
What was the date of your last Smear? Date:	Result:
Was this at your previous GP Surgery? YES □ NO □	Date of last mammogram (if applicable):
Number of ***pregnancies*** (include miscarriages & terminations) (If applicable)	
Do you wish to see a doctor in this Practice for contraceptive services? YES □ NO □	

Other Information
Do you have a "***Living Will***"? (A statement explaining what medical treatment you would not want in the future) YES □ NO □ *If "Yes",* can you please bring a written copy of it to your first appointment.
Have you nominated someone to speak on your behalf (***e.g. a person who has Power of Attorney***)? YES □ *If yes please complete the below information* NO □ Name: Address: Phone number:

Signature of Patient:	Date:
If this form has been completed by someone else, please state their details below: Full Name Address: Relationship: Reason they filled form:	

ONLINE ACCESS TO HEALTH RECORDS REQUEST

In accordance with the UK General Data Protection Regulation (UK GDPR)
Guidance notes – please read before completing this form:

If a child aged 13 or over has 'sufficient understanding and intelligence to enable him/her to understand fully what is proposed' (known as Gillick Competence), then s/he will be competent to give consent for him/herself but may wish a parent to countersign as well. Please note once the child reaches their 16th Birthday access will no longer be available on their parents/guardian's Online service.

- Patients requiring access to their own record (Sections 1, 2 and 7)
- Proxy access to health records where patient has capacity (Sections 1, 3, 5, 6 and 7)
- Proxy access to health records where patient does not have capacity (Sections 1, 4, 5, 6 and 7)
- Parents requiring access to their child's (age 13-17) record (Sections 1, 3, 5, 6 and 7)

Section 1: Patient details

Forename		**Date of birth**	
Surname		**Title**	
Address **Postcode**			
Contact number		**Email address:**	
NHS number (if known)			

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Section 2: Record requested.

I wish to have access to the following online services (please tick all that apply):

Booking appointments	☐
Requesting repeat prescriptions	☐
Access to my medical records	☐

I wish to access my medical record online and both understand and agree with each of the following statements (tick):

I have read and understood the information leaflet provided by the organisation	☐
I will be responsible for the security of the information that I see or download	☐
If I chose to share my information with anyone else, this is at my own risk	☐
I will contact the organisation as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
If I see information in my record that is not about me or is inaccurate, I will contact the organisation as soon as possible	☐

Signed:Date:

Section 3: Consent to proxy access to GP Online Services (if patient has capacity)

- I..... (name of patient), give permission to my GP practice to give the following person/people ..... proxy access to the online services as indicated below in Section 5
- I reserve the right to reverse any decision I make in granting proxy access at any time.
- I understand the risks of allowing someone else to have access to my health records.
- I have read and understand the information leaflet provided by the organisation.

Patient signature		**Date**	

I/We wish to have access to the health records on **behalf of** the above-named patient.

Surname		**Surname**	
First name		**First name**	
Date of birth		**Date of birth**	
Address		**Address**	
Postcode		**Postcode**	
Email		**Email**	
Telephone		**Telephone**	
Mobile		**Mobile**	

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

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Reason for access:

I have been asked to act by the patient	☐
I have full parental responsibility for the patient and the patient is under the age of 18 and has consented to my making this request or is incapable of understanding the request (delete as appropriate)	☐

Section 4: Consent to proxy access to GP Online Services (if patient does not have capacity)

I/We wish to have access to the health records on **behalf of** the above-named patient.

Surname		**Surname**	
First name		**First name**	
Date of birth		**Date of birth**	
Address		**Address**	
Postcode		**Postcode**	
Email		**Email**	
Telephone		**Telephone**	
Mobile		**Mobile**	

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper).

Reason for access:

I/We have been appointed by the Court to manage the patient's affairs and attach a certified copy of the court order appointing me to do so	☐
I am/We are acting *in loco parentis* and the patient is incapable of understanding the request	☐
I am/We are the deceased person's personal representative and attach confirmation of my/our appointment (grant of probate/letters of administration)	☐
I/We have written and witnessed consent from the deceased person's personal representative and attach Proof of Appointment	☐
I/We have a claim arising from the person's death (please state details below)	☐

Section 5: Proxy access online services available

I/We wish to have access to the following online services (please tick all that apply):

Booking appointments	☐
Requesting repeat prescriptions	☐
Access to my medical records	☐

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Section 6: Proxy declaration

I/We wish to access to the medical record online of the above patient and I/we understand and agree with each statement (tick)

I/We have read and understood the information leaflet provided by the organisation and agree that I/we will treat the patient information as confidential	☐
I/We will be responsible for the security of the information that I/we see or download	☐
I/We will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement	☐
If I/we see information in the record that is not about the patient or is inaccurate, I/we will contact the organisation as soon as possible. I/we will treat any information which is not about the patient as being strictly confidential	☐

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health records referred to above under the terms of the Data Protection Act 2018.

You are advised that the making of false or misleading statements in order to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution.

Applicant signature		**Date**	

Section 7: Proof of identity

Under the Data Protection Act 2018, you do not have to give a reason for applying for access to your own health records. However, all applicants will be asked to provide two forms of identification, one of which must be photographic identification before access can be set up. Please speak to reception if you are unable to provide this.

ADDITIONAL NOTES:

Before returning this form, please ensure that you have:

- Signed and dated the form.
- Are able to provide proof of your identity or alternatively confirmed your identity by a countersignature.
- Enclosed documentation to support your request (if applicable).

Incomplete applications will be returned; therefore, please ensure you have the correct documentation before returning the form.

You can return the signed form via our email address at admin.hollies@nhs.net or in person at the surgery or via post.

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This request can take up to 28 days due to the medical records will need to be reviewed by a staff member prior to patient having access due to any third-party information that may need to be redacted.

This may sometimes take longer due to staff shortage, but we will aim to do our best to keep within a timely manner.

Staff use only

Form taken by (Full Name):	*Date:*
Scanned By (Full Name):	*Date:*