Dr Seyan & Partners Registration Form

As a new registration to this practice, we are legally obliged by Government Regulations to assess your eligibility to register for free NHS treatment. Entitlement is based on legal residency, irrespective of nationality, citizenship or any previous payment of NICs or taxes.

Have you been registered with our practice before or had Blood tests or Warfarin checks here: ❑ Yes ❑ No

Personal 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 & Country of Birth……

Address.....

……Postcode……

Out of Area: ❑ Yes ❑ No

If YES then please note the Doctor is under no obligation to visit you at home

Telephone No……..... Mobile No…….....

Email Address…….

Please note that you must inform us of your change of address and contact details when they change otherwise the practice and other health care providers may not be able to provide you with home visit services

Next of Kin Name/Relationship……..

Next of Kin's GP Practice……

Contact Number for Next of Kin……

Foster Children – Details of natural parents/siblings…….....

……

Do you have any communication/Information needs? ❑ Yes ❑ No. If yes please give details ……..

……..

Are you happy for us to share this information with other services ❑ Yes ❑ No

Do you have a Carer? ❑ Yes ❑ No If Yes then Name of Carer and Contact no.

……..

Do you care for a disabled relative or friend? ❑ Yes ❑ No

Name of person you care for and relationship……

…….

Previous GP Details and Previous Address

Previous Address in UK……..

……

Name of previous Doctor……

Address of previous Doctor……

……

Have you returned from the Armed Forces?

Date of Enlistment…… Date of Discharge……..

Address prior to Enlistment……

……..

Would you like access to our Online Service allowing you to book appointments and order repeat medication? (This is available to everyone)

Yes ❑ No ❑ **your password form will be ready to collect in 1 week**

Would you like access to our Online Service allowing you to view your medical record. (NOT AVAILABLE FOR UNDER 16 YEAR OLDS) Yes ❑ No ❑

If yes then please ask reception for the Medical Record Agreement form which you need to sign and hand back. Your Online Access Password will then be ready for you to collect in 1 week.

If you are from Abroad then please complete this next section

Have you got an EHIC card (European Health Insurance Card) Yes ☐ No ☐

Date arrived in UK to live…… If previously resident in UK, date of leaving ……..

Your first UK address where registered with a Doctor……

……

What is the purpose of your stay in the UK? Please tick the appropriate box below:

❑ Work……
State Name and Address of Employer e.g. Copy of Work permit/visa/payslips

❑ Student……
State Name & Address of Educational Facility e.g. Copy of Student Visa and Letter from College or University

❑ Refugee or Asylum seeker……
e.g. Copy of IND/ARC/Home Office papers

❑ Other Reason……
Please give details

Declaration

I have read and understand the reasons I have been asked to complete this form and agree that the relevant official bodies may be contacted to verify any statement I have made. The information given is correct and I understand that if I have knowingly given false information, then action will be taken against me: this may result in referring the matter to the Local Counter Fraud Specialist, Police or Home Office. The Practice may use this information to validate with the above named parties.

Signed by: …… **Date:** ……

Or on behalf of: (child under 16 years)

RECEPTION STAFF TO COMPLETE

Proof of Identity seen ***Please provide a photo ID if possible.***	***Yes*** ❑ ***No*** ❑	***Initial……..***
Proof of Address seen	***Yes*** ❑ ***No*** ❑	***Initial……..***
Patient completed H/C form	***Yes*** ❑ ***No*** ❑	***Initial……..***
If under 5yrs Child immunisation form completed and attached	***Yes*** ❑ ***No*** ❑	***Initial……..***
EHIC Card photocopied	***Yes*** ❑ ***No*** ❑	***Initial……..***
Health Check appointment booked (only for 5 year olds and over)	***Date…….***	***Time…..……..***

ADMIN STAFF TO COMPLETE

Date Registration put on system	***Date……..***	***Initial……..***
Online booking form printed and attached to Health Check form	***Yes*** ❑ ***No*** ❑	***Initial……..***
Add alerts regarding needs of patient		***Initial……..***

Patient's Emis Number……