Windsor Medical Practice

PATIENT REGISTRATION FORM:

SECONDARY / VISITOR (ADULT AND CHILD)

Please complete clearly all relevant sections of this registration form.

Windsor Medical Practice

SECONDARY ③

1. Patient Information				☐
Title:	**Miss / Mr / Mrs / Ms / Mstr / Mx /**	Gender Identity:	☐ Female ☐ Male ☐ Trans ☐ Other	
Family Name:		Marital Status:	☐ Single ☐ Married ☐ Civil Partnership ☐ Separated ☐ Divorced ☐ Other	
Given Name(s):		Ethnicity: Select A and B	A: ☐ White ☐ Black ☐ Asian ☐ Mixed ☐ Other B: ☐ British ☐ European ☐ Other	
Known As:		First Language: If not English		
Previous Family Name:		Resident Since: Month/Year	/	
Date of Birth:		Jersey SS Health Card No: (not required for Visitors)		Seen By:
Reason For Registering with the Practice:	☐ Visitor / On Business / Non-Resident Contractor ☐ Secondary / Specialist Service ☐ Second Opinion			
ID Confirmed:	☐ Yes ☐ No	Photo ID Type: (Passport / Driving Licence)		Seen By:

2. Home Address and Contact Information (For ID purposes Utility Bill/Bank Statement dated within 3 months is valid)					☐
Current Home Address:		Home Telephone:			
		Work Telephone:			
		Mobile Telephone:			
		Personal Email Address:			
Post-Code:		Address Confirmed: Dated within 3 months of issue	☐ Yes ☐ No	Doc. Type:	Seen By:

3. Visitor Information (To be completed by Visitors only)			☐
Jersey Address & Post-Code:		Mobile Telephone:	
		Visitor Status:	☐ Leisure ☐ Business ☐ Work ☐ Other
		Date of Arrival:	
		Date of Departure:	

4. Emergency Contact/Next of Kin Information			☐
Title:	**Miss / Mr / Mrs / Ms / Mx /**	Home Address & Post-Code: ☐ Same as Section 2	
Family Name:			
Given Name(s):			
Date of Birth:		Home Telephone:	
Relationship to Patient:		Work Telephone:	
Is this Your Next of Kin:	☐ Yes ☐ No	Mobile Telephone:	
Consent for us to Discuss Your Record:	☐ Yes ☐ No	Your Official Carer:	☐ Yes ☐ No

5. Private Medical Insurance and Current Employer Information (The Patient is responsible for making all claims with their insurer)			☐
Insurance Provider:		Policy/Scheme Number:	

6. Medical History ☐

Allergies: Do you (or the child) have any known allergies or do you have any adverse reaction to drugs or medication ☐ Yes ☐ No

If Yes please provide details:

Medication: Do you (or the child) currently take any medication?: ☐ Yes ☐ No

If Yes please provide details:

Do you (or the child) suffer from any significant ongoing medical problems or had any serious illness/operations in the past?: ☐ Yes ☐ No

If Yes please provide details:

7. Existing GP Information (Must be completed) ☐

GP Name:		Telephone Number:	
Address:			

8. Patient Declaration, Confidentiality Agreement, Personal Data Statement and Communication ☐

In the case of a child under the age of 16, This declaration should be signed 'for and on behalf of' the child named on this registration form by the Parent/Legal Guardian as given in section 4.

Your Personal Information (Data Protection and Patient Privacy):

The information collected on this application form will be used by **WINDSOR MEDICAL PRACTICE** (hereafter the 'Practice') for the purposes of healthcare related services and practice administration. Personal information we hold about you is processed for the purposes of 'Employment and Social Fields' (Article 8) 'Medical Purposes' (Article 15) and 'Public Health' (Article 16) of the Data Protection (Jersey) Law 2018. This may require your personal data including, relevant details of your medical history, to be shared with other approved healthcare providers for the purpose of referrals and for other lawful purposes related to the Practice procedures. Further information on how we hold and process your data can be found in our Data Protection and Patient Privacy Policy.

General Practice Central Services (GPCS):

All Jersey GP Practices and other approved healthcare service providers, such as the out-of-hours doctors, use a central medical records system known as EMIS. This allows access to a 'shared medical record' to ensure that the provider or clinician has immediate up-to-date and accurate information about your health and any current treatment you may be having. You do however have the right to 'opt out' of sharing some or all of your medical records. Please ask us for more information and where appropriate an Opt-in/Out Form for completion. All approved healthcare service providers with authorised access to GPCS have signed strict confidentiality agreements which are bound by the Data Protection (Jersey) Law 2018.

Your Declaration to us:

- I confirm that all the information I have given in this registration form is accurate to the best of my knowledge.
- I understand that the Practice has the right to accept or decline my registration application at any time.
- I understand that by attending a consultation with a GP or other healthcare professional of the Practice, I accept the Practice terms of service and fee schedule issued and displayed in the Practice premises and as amended from time to time.
- I hereby agree to pay any incurred service fees from the Practice at the time of attendance or treatment.
- I expressly consent that on registration or prior to accepting any credit arrangement from the Practice, where appropriate a credit reference check may be taken with an authorised credit reference agency and/or my previous medical practice(s).
- I give my express permission for the Practice to request information including my medical records from my previously registered GP and I agree to reimburse the Practice for any charges and disbursements incurred relating thereto for the Practice being provided with such information.
- I understand it is my sole responsibility to advise the Practice in writing of any changes made in respect of my personal information.

Signed:	Print Name: (Parent/Legal Guardian if for child named below)	Dated:
Child Name:	Date of Birth:	

For Practice Use Only	On EMIS By:	☐ Secondary Registration ☐ Temporary	EMIS Number:
Medibooks:	Synchronised:	Billing Pattern:	Alternative Billing Address (Child)