ISLAND MEDICAL CENTRE

Patient Registration Form: ADULT

Individual patient registration forms must be completed for each adult and young person over the age of 16.
Please complete clearly all relevant sections of this registration form.

PRIMARY

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:		Reason For Registering with the Practice:	☐ Transferring from another Jersey GP Practice ☐ Re-Registering with GP Practice ☐ New Resident In Jersey		
Jersey SSD No/Card:	Seen By:				
Jersey SSD HIF Status: (For Practice to complete)	☐ HIO ☐ HMA ☐ Private	Identification Confirmed: (Passport / Driving Licence)	☐ Yes ☐ No	ID Type:	Seen By:

2. Home Address and Contact Information (For ID purposes Utility Bill/Bank Statement or Tax/SSD Notification dated within 3 months is valid) ☐					
Current Home Address (1):		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:
Access Information: for impaired patient visits					

3. Previous Home Address (If less than three years at the current home address) ☐			
Previous Home Address (2):		Previous Home Address (3):	
Date From / To:	/	Date From / To:	/

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:	
Your Next of Kin:	☐ Yes ☐ No	Mobile Telephone:	
Consent for us to Discuss Your Record:	☐ Yes ☐ No	Your Official Carer:	☐ Yes ☐ No

5. Children Under 16 that you are the Parent or Legal Guardian (Registrations Form to be completed for all those registering with the practice) ☐		
Child Full Name:		Date of Birth:
Child Full Name:		Date of Birth:
Child Full Name:		Date of Birth:
Child Full Name:		Date of Birth:
Child Full Name:		Date of Birth:

6. Previous/Existing GP Information ☐			
GP Name:		Telephone Number:	
Address:			
Reason for Transferring:			

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

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

Your Personal Information (Data Protection and Patient Privacy):
The information collected on this application form will be used by Island Medical Centre (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:	Dated:

For Practice Use Only	On EMIS By:	☐ Pre-Registration ☐ Regular ☐ Private	EMIS Number:
Medibooks:	Synchronised:	Billing Pattern:	Alerts:
Past medical records requested*	Date:	Requested By:	Received Date:
Other GP Informed of Registration:	Date:	Informed By:	Check Requested:

- *Send copy of Page 2 section 8 (signed) to existing GP as authorisation to release medical records to the Practice and amend EMIS patient type*
- *Individual Form 2 to be completed for each child under age of 16*
- *Separate registration forms to be used for those aged 16 and over, Visitors or Secondary users of the practice.*

Medical History/Assessment Form

Patient Name:		Date of Birth:	

9. Patient Summary Medical History ☐

	Have you ever had any of the following	Please Tick	If answered 'yes' please give details.
1	Epilepsy, fits, blackouts, fainting turns or unexplained loss of consciousness?	☐ Yes ☐ No	
2	Vertigo, dizziness, giddiness, problems with balance?	☐ Yes ☐ No	
3	Recurrent headache or migraine?	☐ Yes ☐ No	
4	Diseases of the nervous system e.g. neuritis, stroke, multiple sclerosis?	☐ Yes ☐ No	
5	Chest pain, angina, heart disease or breathlessness?	☐ Yes ☐ No	
6	Any visual defect e.g. scotoma, blindness in one eye, reduced visual field, blurred vision, coloured blind?	☐ Yes ☐ No	
7	Raised or low blood pressure?	☐ Yes ☐ No	
8	Any blood disorder?	☐ Yes ☐ No	
9	Asthma, bronchitis, emphysema, pneumonia or any other lung disease?	☐ Yes ☐ No	
10	Jaundice or any form of hepatitis or other liver problem?	☐ Yes ☐ No	
11	Any kidney or bladder conditions?	☐ Yes ☐ No	
12	Arthritis, gout, chondromalcia patellae or rheumatism?	☐ Yes ☐ No	
13	Any metabolic disorder including diabetes, thyroid and adrenal gland disease?	☐ Yes ☐ No	
14	Psoriasis, eczema, allergic skin rash or other skin disorder?	☐ Yes ☐ No	
15	Any infectious diseases?	☐ Yes ☐ No	
16	Anxiety/depression, mental breakdown or stress related problems?	☐ Yes ☐ No	
17	Sleep related issues?	☐ Yes ☐ No	
18	Substance misuse (e.g. drugs, steroids)?	☐ Yes ☐ No	
19	Any malignancies or cancers?	☐ Yes ☐ No	
20	Any operations or surgical procedures?	☐ Yes ☐ No	
21	Ear or hearing problems?	☐ Yes ☐ No	
22	Have you ever consulted an orthopaedic surgeon, chiropractor, osteopath or physiotherapist?	☐ Yes ☐ No	
23	Current treatment. Are you currently attending a hospital/GP for treatment or waiting for an appointment?	☐ Yes ☐ No	
24	Any other medical condition we should be aware of?	☐ Yes ☐ No	

10. Other Medical History ☐

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

If Yes please provide details:

Do you currently take any medication?: ☐ Yes ☐ No

If Yes please provide details:

Smoking History. Do you or have you ever smoked? ☐ Yes ☐ No

If Yes how much do you smoke per day: How long have you smoked for? Number of years given up?

What is your average intake of alcohol per week in units?: Units

How often do you have a drink containing alcohol? (Please circle)
Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week

How many units of alcohol do you drink on a typical day when you are drinking?
1-2 3-4 5-6 7-9 10 or more

How often have you drunk 6 or more units on a single occasion in the last year?
Never Less than monthly Monthly Weekly Daily or almost daily

(Pint of Regular Beer/Lager/Cider = 2 Unit / Standard Glass of Wine = 2 Units / Bottle of Wine = 10 Units / Single Measure of Spirits = 1 Unit)

Female Patients: over 18 years of age;	Date of last cervical cytology/smear test: Date: Result: Date of last mammogram if carried out: Date: Result:

Please give further information that you feel may be relevant to your medical history.

11. Family Medical History (If Known) ☐

Family Member	Age / Deceased	Heart Disease	Hypertension	Diabetes	Cancer	Mental Health	Cause of Death (if known)
Mother		☐	☐	☐	☐	☐	
Father		☐	☐	☐	☐	☐	
		☐	☐	☐	☐	☐	
		☐	☐	☐	☐	☐	

12. Social Activities ☐

Exercise taken on a normal weekly basis	None	Less than 1 Hour	1-3 Hours	Above 3 Hours
Physical exercise such as swimming, jogging, sports, gym workout	☐	☐	☐	☐
Cycling including to work and leisure time	☐	☐	☐	☐
Walking including to work and leisure time	☐	☐	☐	☐
Gardening/DIY	☐	☐	☐	☐
Which sports or other exercises do you do?				
How would you describe your walking pace?	☐ Slow ☐ Steady ☐ Brisk ☐ Fast			

For Practice Use Only	Received By:	On EMIS By:	EMIS Number: