ISLANDHEALTH

L'Aumone - St Sampson's - Town

www.islandhealth.co.uk

NEW PATIENT REGISTRATION FORM

PLEASE COMPLETE FORM IN CAPITAL LETTERS

All Sections MUST BE completed to enable your prompt registration to the Practice as a patient

Patient No:……………….……..…..

SEX: MALE / FEMALE / OTHER

SURNAME:……..……………………………………………....……FORENAMES:……………………………..…………………………..…..MR/MRS/MISS/MS/MASTER/OTHER………………..

MAIDEN NAME:………………...………………………………..…..……………DATE OF BIRTH:………………...……………..……..……RELIGION:…………...……….....…………………...

ADDRESS:………………...……

……………………………...………POST CODE:…………………..

TELEPHONE NUMBERS:HOME…………….……..WORK…………...…………..MOBILE……………….....…..………………..EMAIL ADDRESS:………....………………………………

OCCUPATION:……………………...………………..……EMPLOYER:……………..……………………………………………………………ADDRESS:……………….……………………………

………………...………POST CODE:…………….........

IMMUNISATIONS IN THE LAST 12 MONTHS:………..

(FOR FEMALE PATIENTS OVER 21) Date of Last Smear:…………………………………..……………. Result:………………………………………………………………………………

INSURANCE STATUS:(eg BUPA, Foresters, Oddfellows, PPP, WPA etc)………………………………..……..……..INSURANCE SCHEME NUMBER:……………….........……..……

GY HEALTH BENEFIT NUMBER……………..…………….

CHILDRENS NAMES (*each child must have own registration form*)

……………………………………………..……………..…..……..……DOB…………………… ……………………………………………..……………..…..……..……DOB…………………………

……………………………………………..……………..…..……..……DOB…………………… ……………………………………………..……………..…..……..……DOB…………………………

NEXT OF KIN:………………………………...……………………...…………………….......……......ADDRESS:……………...………………………………………………………………

……………………...……POST CODE:…………..…………..

RELATIONSHIP:…………………....……..…………TELEPHONE NUMBERS:HOME…………………..….WORK………………………...MOBILE……………..........……………………

IF YOU HAVE MOVED TO GUERNSEY IN THE LAST YEAR PLEASE STATE:

Date of Arrival:………………………………………….....Intended Length of Stay:……………………………………Previous Address:…………………………………………………………

……POST CODE:……………………..

WITH WHICH DOCTOR WOULD YOU LIKE TO BE REGISTERED? …………………........……………………………PREVIOUS DOCTOR:…………………………………………………

PREVIOUS DOCTORS ADDRESS:………………...………………………..……..........

……………………...…....…………………...…..POST CODE:……………………………..TELEPHONE NUMBER:……………………………………………

Have you any known allergies (eg medicines, stings, animals etc)? YES/NO *(please give details)* ……………………………………………………………………………………………

Are you on any medication at the moment? YES/NO *(please give details)* ……..

Have you had any past serious illness or operations? YES/NO *(please give details)* ………………………………………………………………………………………………………..

I understand that the Practice has the right to accept or decline this application.

I agree to pay for all treatment given by the Practice at the time of treatment. Failure to do so may result in recovery of outstanding debt being passed on to a third party for recovery of the debt on the Practice's behalf. No medical information would be passed over to the third party recovery agent.

I agree that the Practice may disclose personal details and details of medical records regarding both myself and my dependants to all those involved in providing me/them with healthcare and related services both inside and outside the Practice.

Please see IslandHealth's Privacy Notice in relation to any of your data we may hold.

I give my permission to the Practice to request information from my previous doctor and I agree to meet reasonable charges relating thereto.

SIGNED:…………………………………………………………………………………………………DATE:…………………………………………………

UPON COMPLETION, PLEASE RETURN THIS FORM WITH FORMAL PHOTO ID TO EITHER OF THE SURGERIES BELOW

L'Aumone Surgery tel: 256517 **St Sampson's Medical Centre tel: 245915** **Town Surgery, Frances House tel:724747**

For Office Use Only: Copy to A/c's……..

Received By:……………………………….. 9344………………… Med Rec…………… Scanned……………………………………..

Date Received………….……. Registered on Computer By………….…….. Registration Book………….… ID Copied………...…….. JUNE 2018