



**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).....

Have you ever worked in the Armed Forces? 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.....