Welcome to Billericay Medical Practice

Please ensure you complete **all forms thoroughly**, including the separate GMS1 form, using your full legal name.

Your registration with **Billericay Medical Practice** will be completed within 2 working days.

In order for your medical records to be brought up to date, can you complete the information requested on the enclosed New Patient Questionnaire, giving the correct detailed information will enable the practice to complete your registration more quickly and efficiently.

Please answer all questions as they could be important to your medical care.

Before the Partners will consider anyone joining their list you must provide the following documentation in person. These documents must contain your ***FULL LEGAL NAME*** and ***PERMANENT ADDRESS***, dated within the last three months.

Completed registration forms

Completed GMS1 form

Proof of Legal Name
Valid Passport, Birth Certificate or
Photo card Driving Licence

Proof of Residence one of the following (*dated within the last three months*)
Bank Statements
Utility Bills
Telephone Bills
Solicitor, Estate Agent or Landlord Agreement

Patient Online Registration
If you wish to register for the above, please return the completed attached form and this must be accompanied with photo id (passport, driving licence etc.)

PLEASE NOTE: Only original documents will be accepted. These will be handed back to patient at time of registering.

If you wish to opt out of Organ or Blood Donation, please register at www.nhsbt.nhs.uk (please ignore the front of the purple GMS1 form regarding this)

Any name changes need to be verified with proof i.e. marriage certificate or deed poll document.

Information about the services we offer can be found in our Practice Booklet or via our Website.

www.gpsbillericayhealthcentre.co.uk

Patient Agreement

1. Agree to book a ***routine*** appointment whenever possible.
2. Only request ***urgent*** appointments in the case of a ***genuine medical emergency***.
3. ***Home*** visits should only be requested for ***housebound*** patients or patients who are genuinely unable to come to surgery. (Transport remains the responsibility of the patient).
4. Calls outside surgery hours and especially those at night should be strictly made only for ***genuine medical emergencies***.
5. Always treat the Receptionist and all the staff with courtesy and respect and they will do likewise. The surgery has a ***zero tolerance policy*** towards any patient using offensive language or behaviour.
6. Always ***cancel*** appointments where possible within 24 hours, appointments should not be made and not kept.
7. Patients to do whatever possible to improve their own health.
8. Request for sick notes should only be made after the first 7 days of illness.
9. Requests for repeat prescriptions should not be requested during consultation with the doctor or over the telephone.
10. Doctor consultations are limited to 10 minutes.
11. Antibiotic treatment is not available for cold and viruses.
12. When moving out of the surgery's catchment area, patients must register with a new GP.

Patients Name……. DOB …….

Patients Signature…… Date……..

For Office Use Only

1. Name ID:
2. Address ID 1:
3. Address ID 2:
4. If Patient Online Registration Form completed, check photo id and note relevant details on form for entering on system:
5. Documents seen and authorised

Receptionist Signature …… Date …….

Ethnicity Questionnaire

Please complete and return this questionnaire as part of our welcome pack

Name ..... DOB .....

I would describe my ethnic origin as:

- ❑ British or Mixed British
- ❑ English
- ❑ Irish
- ❑ Scottish
- ❑ Welsh
- ❑ Or any other? Please specify if you wish …….

Asian

- ❑ Bangladeshi
- ❑ Indian
- ❑ Pakistani
- ❑ Any other Asian background - Please specify if you wish ……

Black

- ❑ African
- ❑ Caribbean
- ❑ Any other Black background – Please specify if you wish ……

Chinese

- ❑ Any Chinese background

Mixed ethnic background

- ❑ Asian and White
- ❑ Black African and White
- ❑ Black Caribbean and White
- ❑ Any other Mixed background – Please specify if you wish ……..
- ❑ Any White background - Please specify if you wish ……..
- ❑ Any other ethnic background - Please specify if you wish ……

Language

- ❑ What is your main spoken language? …….
- ❑ Are you an English speaker? – Yes / No

Registration Form (Only For Under 16 Year Olds)

At least one parent and/or guardian is to be registered at the Practice

Child's Details:

Full Name …… DOB ……..

Address ……

……. Post Code ……..

Telephone Contact No: Home…….. Mobile ……..

Details of Person filling in form:

Name …….. DOB……..

Address ……..

……. Post Code ……

Telephone Contact No: Home…… Mobile ……..

What relationship do you have to the child?
(e.g. Parent, Step Parent, Guardian, Foster Carer) ……..

Family Details:

Mother's full name …… DOB……

Father's full name …….. DOB……

Names & DOB of siblings ……..

……..

……..

Name and relationship to child of any other household members …….

……

……

Address of Mother/ Father* (if different from child) *delete as appropriate

……

…… Postcode ……..

Name and address of most recent school or nursery ……

..... Postcode ……

FAMILIES RECEIVING ADDITIONAL SUPPORT

Does your child have a social worker? ☐ Yes ☐ No

If yes, please give their name, address and contact number ……..

.....

Telephone number ……..

Is the child in a care home or fostered? ☐ Yes ☐ No

Who has Parental Responsibility? ……

Details of any other Agencies involved? ……

……

……

……

Signature …… Date …….

This information will be shared with our Child Health Department and members of the Primary Healthcare Team.

If you do NOT want this information to be shared please tick here ☐

New Patient Health Check Medical History Form

1. PERSONAL DETAILS:

Surname: …… Date of Birth: ...../...../.....

Forenames: ……

Marital Status: Single / Married / With Partner / Divorced / Separated / Widowed

Full Address: …….

Post Code: ……..

Home Phone No: ..... Mobile No:.....

Daytime Contact No of parent/ guardian: …… .....

Place of Birth: Town ..... County…….. Country .....

Full Name & Address of previous doctor ……..

……. .....

Next of Kin: Name …….. Relationship .....

Address …….. Contact No .....

We will send you SMS messages unless you wish to opt out.

If you wish to opt out, please sign here……

2. ARE YOU A CARER? No / Yes (If you are, please ask at reception for a Carer Registration Form)

3. HAVE YOU EVER SERVED IN THE BRITISH ARMED FORCES? YES/NO

4. PATIENT PARTICIPATION GROUP: This Practice is committed to improving the services we provide to our patients, to do this it is vital that we hear from people like you about your views and experiences. Please let us know if you are interested **YES / NO** or ask at reception for an application form.

5. WEIGHT: ..... **HEIGHT:** .....

6. ALLERGIES: Please give details of any allergies (e.g. medicines, eggs, nuts, vaccines or chickens)

Cause (e.g. drug name)	**Nature of reaction** (e.g. rash, lip swelling)

7. PRESENT MEDICATION: (Please list all medicines, pills, inhalers, etc

Please make an appointment with the doctor if you use medication regularly

8. MEDICAL HISTORY: Do you have or ever had any of the following? Please tick Yes or No and give dates first suffered & details where appropriate.

CONDITION	Y	N	DATE	Details
Asthma				
Chronic Bronchitis/Emphysema				
Stomach or bowel trouble				
Cancer				
Diabetes				
Epilepsy / Fits				
High Blood Pressure				
Thyroid Trouble				
Stroke				
Mental Health Problems				
Heart Attack				
Angina				
Kidney Disease				
Other (give details):				

9. Family History

Has any of your close family (mother, father, sister, brother) had serious illness under the age of 60?

10. IMMUNISATIONS:

TYPE	DATE	TYPE	DATE	TYPE	DATE
Tetanus		Rubella		Typhoid	
Diphtheria		Polio		Hepatitis A	
Measles		Whooping Cough		Hepatitis B	
Mumps		TB		Other:	

11. GIRLS ONLY QUESTIONS:

Are you currently pregnant? : YES / NO If yes, expected date of delivery: .....

12. OTHER INFORMATION: Please write below details of any other information you feel should be included in your medical records, for example serious accidents or operations (continue on separate sheet if necessary)

Signed ..... Date.....

Smoking Status

Please note we are required by the Department of Health to include this form in the Under 16's New Patient Registration under Quality Outcome Framework

Please provide the following information so we can update your records accordingly.

Name ..... DOB .....

Are you currently a:

- ❑ Smoker if so how many per day.....
- ❑ Ex-Smoker Date stopped.....
- ❑ Never Smoked

Would you like help to Quit?

Do you wish to find out more about the services the Practice can offer?

- ❑ Yes
- ❑ No

Would you be happy for us to contact you regarding services available in the future?

- ❑ Yes
- ❑ No

Alcohol Screening

Name ..... DOB .....

1 unit is typically:

Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

The following drinks have more than one unit:

A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%)

UNIT GUIDE

AUDIT- C Questions *(9k17.)*	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per 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+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
				TOTAL :		

A score of **less than 5** indicates *lower risk drinking*

Scores of 5+ requires the following 7 questions to be completed:

AUDIT Questions (9k15.) (after completing 3 AUDIT-C questions above)	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
				TOTAL		

If your total score indicates an increased risk, you may be invited for a health screen with a nurse/ doctor or be given further information regarding safe alcohol consumption.

Electronic Prescribing

All of our patients who have a repeat prescription now have to use the Electronic Prescription Service (EPS).

1. Electronic prescriptions help you, your doctors and the environment. You can help save NHS funds by nominating the pharmacy of your choice to receive your prescriptions electronically. Ask practice staff for more information.
2. Did you know that the NHS spent a significant amount more money processing and storing paper prescriptions? Electronic prescriptions save you time, save NHS funds and help the environment.
3. We're making things easier for you by sending your prescriptions electronically to your pharmacy, ready for you to collect your medicines.
4. Most prescriptions in the country are now sent by EPS.

Please arrange to send all future prescriptions to the nominated chemist of my choice and if this changes I understand that it is my responsibility to notify the surgery.

Name ..... DOB .....

Chemist Name ……

Chemist Address ……

Post Code ……..

Signature …….. Date ……

Patient Online Registration Form

Access to GP online services: Booking appointments
Requesting repeat prescriptions
Accessing full medical records
Please note that if you request access to your medical records, this can take up to 21 days from the date request is received.

Please note that signed photo id is required (in date passport/photo driving licence etc.)

Surname				
First name				
Date of birth		Age if under 16		
Address				
Postcode				
Email address				
Telephone number		Mobile number		
		Do you want SMS Text Message Reminders	Yes	No

1. I have read and understood the information on the reverse of this form	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	☐

Signature on behalf of patient if under 16 years of age Please state relationship :	Date
Signature	Date

For practice use only

Identity verified through (tick all that apply)	Vouching ☐ Vouching with information in record ☐ Photo ID ☐	Name of verifier	Date
Name of person who authorised (if applicable)			Date

Important Information
Please read before returning this form

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It's your choice.

It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.

If you can't do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

Before you apply for online access to your record, there are some other things to consider.

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

Forgotten history There may be something you have forgotten about in your record that you might find upsetting.
Abnormal results or bad news If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.
Choosing to share your information with someone It's up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.
Coercion If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.
Misunderstood information Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.
Information about someone else If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.

More information

For more information about keeping your healthcare records safe and secure please visit our website: www.gps-billericayhealthcentre.co.uk

Your emergency care summary

Opt-Out Form

CONFIDENTIAL

Request for my clinical information to be withheld from the Summary Care Record

If you DO NOT want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s).....

Address.....

Postcode ..... Phone No ..... Date of birth .....

NHS Number (if known) ..... Signature .....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature.....

Relationship to patient ..... Date .....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

Your records will stay as they are now with information being shared by letter, email, fax or phone.
If you have any questions, or if you want to discuss your choices, please contact your GP practice.

Actioned by practice: yes / no

Date.....