THE CHISLEHURST MEDICAL PRACTICE

Patient Registration Form – please PRINT use black ink

All information supplied is treated confidentially and forms a part of you medical record.

Surname: .....Married/ Single /Widowed/ Divorced

First Names:
.....M/F.....

Maiden or former name: .....

Address; .....

.....

Tel No Home:.....
Mobile:..... Patients aged 13 years and over must have an individual number attached to their record.

Is this a foster child? Yes ☐ No ☐
If yes is this a private fostering arrangement Yes ☐ No ☐

Date of Birth:.....

School Attended.....

Place of Birth: .....Mothers Maiden Name.....

Next of Kin

Title.....First Name.....Surname.....

Address.....

Contact No.....Relationship.....

Are you are carer? If so please give details .....

Does someone care for you? If so please give details .....
.....

ABOUT YOU

Height: ……. Weight: …….

Are you allergic to anything? Yes /No Details: ……..

Are you on regular medication? Please attach a repeat request form from your previous surgery.

Have any of your immediate relatives suffered from any of the following:-

Please tick as appropriate	Relative e.g. mother, sister	Under 60	Over 60
Angina or Heart Attack			
Stroke			
High Cholesterol			
Asthma			
Diabetes			
Cancer (please specify)			
High Blood Pressure			

Please add any other information that you would like the doctors to know about you. Please include any special requirement such as disability access.

……

……

……

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What is your ethnic group? Please tick the appropriate box

White	British		Irish		Any Other White background			
Mixed	White & Black Caribbean		White & Black African		White & Asian		Any Other Mixed background	
Asian or Asian British	Indian		Pakistani		Bangladeshi		Any Other Asian Background	
Black or Black British	Caribbean		African		Any Other Black Background			
Other	Chinese							

If your first language is NOT English please complete

First language Spoken……Interpreter Required Yes/No

CONSENT OPTIONS

If you require further information regarding consent please visit the Practice Website www.chislehurstmedicalpractice.co.uk

The surgery sends text reminders, recalls and urgent messages via text. It is your responsibility to notify us of any changes to your mobile number in writing.
If you wish to receive reminder you MUST consent here
☐ **I consent to receiving SMS text messages from the surgery**

☐ **I do not wish to receive SMS text messages from the surgery**

Getting in touch is sometimes difficult. Currently we do not leave voice messages without patient consent. Please indicate if you would like us to leave you a brief message.
☐ **I consent for messages to be left on my mobile voicemail and understand my responsibility as set out below:-**
It is essential that you ensure that we have the most up to date mobile number for you. Updates to this information can be done when booking an appointment or in writing.

In the future we may to wish to communicate with you via email. Please indicate if this would be a useful option for you and you would like to use this facility.
☐ **I consent to receiving communication via email and understand my responsibility as set out below:-**
It is essential that you understand that you are responsible for ensuring that we have the correct email address and who has access to this information– updates only accepted in writing via change of details form –

All patients automatically have a Summary Care Record created. Please indicate if you do not wish to have one
☐ **I do not consent to a Summary Care Record**

If you would like to register for online access please see the next pages and complete the information required

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CHISLEHURST MEDICAL PRACTICE

PATIENT ACCESS REGISTRATION FORM

MAKE APPOINTMENTS, REQUEST REPEAT PRESCRIPTIONS & VIEW YOUR MEDICAL RECORD ONLINE

Once you are registered for the Patient Access System you are able to; - make appointments, request prescriptions and view your GP medical record online. The Patient Access medical record viewer allows you to look at test results, details of consultations and your medical history, including current and past medication.

If you would like to have secure online access to your records, we need to make sure that you understand what this involves and that you are happy for us to use the information provided below to set up and operate the service. **You will need to provide two forms of ID;- one form of photographic ID e.g. Passport or driving licence AND one form of non-photographic ID e.g. utility bill, benefits letter , bank card etc.**

The following form will take you through the things you need to think about. By signing this form you accept the declarations listed below and will be giving us your permission to go ahead with setting up the service for you (subject to your specific access requests). If you decide not to join, or wish to withdraw, it will not affect your treatment in any way.

The practice makes every effort to record information as accurately as possible, however there may be information that you do not feel is correct.

Conditions of Use and Declaration (please read the following and sign to accept):

1. I have read and understood this information leaflet about this service and access to GP medical records.

2. I agree to use the system in a responsible manner in accordance with all instructions given to me by the practice. If not, access may be withdrawn.

3. If I see information which does not relate to me, I will immediately log out and report the matter to the practice as soon as possible.

4. I agree that it is my responsibility to keep my username and passwords secure. If I think these have been shared inappropriately I will reset them using the instructions supplied. I am also responsible for keeping safe any information I may print from the record.

5. I agree that my details below may be used to contact me about how useful I find the service and whether it could be improved.

6. If I notice any inaccuracies with my record, I will inform the Practice Manager as soon as possible of any errors or omissions.

7. I understand that I may see information on my record that I was unaware of / have forgotten about that could cause distress.

8. I understand that, as before I will be informed directly by the practice, of any test results which require further action. However I understand that I may see these results online before the practice has been able to contact me. This could be while the surgery is closed and there is no one available to discuss them with me.

KEEP THIS PAGE FOR REFERENCE

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NEW APPLICANTS

PATIENT ACCESS REGISTRATION FORM
MAKE APPOINTMENTS, REQUEST REPEAT PRESCRIPTIONS & VIEW YOUR MEDICAL RECORD ONLINE

PATIENT DETAILS AND DECLARATION

Full Name of Patient:
Date of Birth:
Full Address
Postcode:
Contact Tel number:
E-Mail Address:

PARENTS/GUARDIANS

Patient Access is only available for children aged 13 years and over unless the child has a special requirement for Access which will be granted with the consent of the GP.

If you are requesting access on behalf of a child (up to 13 years) or for a patient for whom you have legal responsibility please give your details below:

Name of Parent/Guardian: _____
Address of Parent/ Guardian:
Contact Tel Number:_____
Relationship to patient: _____

I have NOT yet registered and wish to request login details and a password to use PATIENT ACCESS ☐
TICK HERE IF YOU ALSO WANT ACCESS TO THE MEDICAL RECORD VIEWER☐
TICK HERE IF YOU WISH TO SEE DOCUMENTS FEOM MARCH 2017 ONWARDS ☐
I confirm that
☐I am the patient detailed above
☐Please email my exclusive PIN to……..
Photo ID Seen at request for Appointments & Prescribing only
Passport/Driving Licence/Other please specify
…….

☐I am the legal parent/guardian of the child named above and the child is under 13.
Or
☐I have legal responsibility and consent to access the record of patient named above

All Applicants I have read and accept the conditions of use

Signed: _____ Date: _____

For Office Use Only
Emis No:
Date
Agreed by GP Yes/No Signed……
ID Seen: Passport / Driving Licence / Other (Please specify)……
Taken by:
Actioned: Yes/No

FAMILIES WITH CHILDREN UNDER 5

If you are a family with children under the age of 5 yrs please make sure you have filled in the Health Visitor contact form .

The Health Visitor connected to the surgery

Kay Okoro

Can be contacted by telephone at Mottingham Clinic 020 8857 6028 and hold drop-in clinics twice weekly as follows:

Tuesday morning 9.15am – 11.30am
The Willows Clinic Red Hill in Chislehurst

or

Thursday morning 9.15am – 11.30am
Castlecombe Children and Family Centre in Mottingham

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