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.

Name:……

Tel No Home:…… **Mobile:…….** Patients aged 13 years and over must have an individual mobile number.

Email address (must be different for each individual)…….

Nominated Pharmacy for your medication ……..
(This is sent electronically)
Please attach a copy of your latest list of medication to your application

School currently attended……..

Next of Kin Name:…….
ContactNo……
Relationship to you……..

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

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

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

All patients registered at this surgery will automatically have a summary care record created unless they have expressed a specific preference to opt out. To learn more visit www.nhs.uk/your-nhs-data-matters or call 0300 303 5678
The Practice also has access to the Local Care Record.
More information can be found on the website www.chislehurstmedicalpractice.co.uk

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

ONLINE ACCESS

All patients over 16 will automatically be enrolled for online access to their medical record for appointment booking and requesting medication. If you require access for anyone under 16 or full access to your record please complete the form at the end of this document

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 –

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 one form of photographic ID e.g. Passport or driving licence**

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

PATIENT DETAILS	
FULL NAME	
DATE OF BIRTH	
FULL ADDRESS	
MOBILE NUMBER	
EMAIL ADDRESS	

If you are requesting on behalf of a child under 13 or for a patient for whom you have legal responsibility, please give your details below

PARENTS/ GUARDIANS & CARERS	
FULL NAME	
DATE OF BIRTH	
FULL ADDRESS	
MOBILE NUMBER	
EMAIL ADDRESS	
RELATIONSHIP TO PATIENT	

PLEASE TICK AS APPLICABLE	
I have not yet registered and wish to request access to view my medical record	
I have read and accept the conditions of use	
PLEASE TICK ONE OPTION BELOW	
I am the patient detailed above	
I am the legal parent/ guardian of the child named above and the child is under 13	
I have legal responsibility and consent to access the record of patient named above	

Signed		Date	

OFFICE USE ONLY - PHOTO ID SEEN							
PASSPORT		DRIVING LICENCE		FREEDOM PASS		OTHER	
DATE				CHECKED BY			