A logo for a clinic

Description automatically generated

**REGISTRATION FORM**

**Please ensure you *sign* in the following areas: *Page 5,* Eligibility Form and *Page 6*, Acceptable Behaviour Contract. Incomplete registration forms will result in a delay in registration.**

Forename: ……………………………………………………. Surname: …………………………………………….

Date of Birth: ……………………………………………….… NHS Number:…………………………………………

Previous GP: ……………………………………………….…

Please Tick if under 16:

Please Tick if you are homeless due to the following:

* You are sleeping rough
* Living in insecure/temporary housing
* Living in Short term hostel
* Living in Bed & Breakfast accommodation
* Living in Domestic Abuse refuge
* Sofa surfing
* Other

Please tick if refugee/asylum seeker status: Yes No Date entered UK: …………………

**If you have recently entered the UK and not**

**yet registered with a GP, please provide the …………………………………………………………………….**

**date you first came to live in the UK**

**Do you own a firearms licence: Yes: No: Expiry Date:……………………….**

Address: ……………………………..……………………………………………………………………………….

……………………………..……………………………………………………………………………….

Mobile Number: ……………………………..………………………………………………………..

Home Number: ……………………………..…………………………………………………………

Email Address: ……………………………..………………………………………………………….

I confirm that I ***give the surgery permission to contact myself via email/text*** as a form of communication.

Yes No

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities and knowing your origin may help with the early identification of some of these conditions.**   |  |  |  | | --- | --- | --- | | **White**  **Welsh, English, Scottish, Northern**  **Irish or British**  **Irish**  **Gypsy or Irish Traveller**  **Any other White Background**  **Black. Black Welsh, Black British, Caribbean or African**  **Caribbean**  **African**  **Any other black, black British**  **or Caribbean background** |  | **Asian, Asian Welsh or Asian British**  **Indian**  **Pakistani**  **Bangladeshi**  **Chinese**  **Any other Asian Background**  **Mixed or multiple ethnic groups**  **White and Black Caribbean**  **White and Black African**  **White and Asian**  **Any other mixed or multiple ethnic**  **background** | | **Other ethnic group**  **Arab**  **Any other ethnic group** |  | **Prefer not to say** | |
| **Do you need a BSL interpreter or language interpreter, if so what language?**  **BSL: Yes No**  **Language interpreter Yes No Language: …………………………….…………..** |

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| **VETERAN STATUS-are you a veteran?** | **Yes No** |

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| --- | --- |
| **CARERS IDENTIFICATION:** Carers are people who look after relatives or friends who cannot manage at home without help. This may be because they have a disability/illness or because they are frail. | |
| Are you a carer for someone else? | **Yes No** |
| **If yes please give details:** |
| Do you have a carer? | **Yes No** |
| **If yes please give details:** |

|  |  |
| --- | --- |
| Occupation: |  |

|  |  |
| --- | --- |
| Do you smoke?  **Yes No** | |
| If YES how many per day? |  |
| Do you currently use e-cigarettes (vape) ?  **Yes No** | |
| If you vape, how often do you use e-cigarettes?  Daily  Weekly  Less often  Rarely | |
| St David’s is committed to assisting our patients to give up smoking through Cessation Clinics and medication. **Would you like any further advice or help? Yes No** | |

|  |  |
| --- | --- |
| How much alcohol do you drink a week?  (1 pint of beer equals 2 units)  (1 glass of wine equals 1 unit)  (1 short measure equals 1 unit) |  |

|  |  |  |
| --- | --- | --- |
| Height: | Weight: | Blood Pressure: |

|  |  |
| --- | --- |
| What is your medical history?  *Please provide any immunisation information if you can: (children will have a red book, please bring this along so we can take a copy of this)* |  |
| **FAMILY HISTORY:**  *Please tell us about your immediate family. Any illness such as heart disease, stroke, blood pressure, asthma or diabetes* |  |
| **MEDICATION**  If you are prescribed regular medication, please provide one of the following:   * **Repeat slip, can be obtained from your previous surgery.** * **GP Print out** * **Recent Hospital Discharge** * **Prison Discharge**   **If this is not** **provided it may delay your medication. This needs to be an updated list (within the last 3 months).**    If this is not possible, please list all medication you are currently taking including dosage and frequency, (this includes oxygen).  ***Please COMPLETE THE TICK BOX if you are taking warfarin AS YOU WILL BE REQUIRED TO ATTEND THE***  ***SURGERY FOR INR MONITORING*** | **Warfarin** |

**You can request your medication from your previous GP Practice until the registration process is complete.**

***Eligibility Form***

I am a permanent resident in the UK (Wales).

I am an ordinary resident in the UK (Wales) for a settled purpose (work, study) for at least six months.

I have formally applied for asylum in the UK and my application is still under consideration by the Home Office.

I am a refugee who has been given leave to retain in the UK.

I am an EEA National (Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Irish Republic, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and Switzerland). **NEEDS VALID EHIC CARD**.

I have an emergency problem which requires necessary treatment immediately (e.g. chest pain that may indicate heart attack). This would not include having forgotten medication.

I am not eligible for NHS treatment and need to be seen as a private patient.\*

\* Charge: £80 for ten minute consultation

(Please be aware that there will be a charge payable to the chemist for a private prescription and the medication).

I am applying for registration as a patient at this practice at this practice and I declare my eligibility as identified above. I understand that if my declaration is later found to be false, I may immediately forfeit my right to treatment as this practice and maybe liable for the cost of treatment.

**Signed: …………………………………………… Date: ………………………………………….**

**(If registering a child, signature of parent or guardian)**

**REGISTRATION OF CHILDREN:**

Please confirm below that both parents have parental rights for the child. If only one parent has parental rights, please indicate below:

**We confirm that BOTH parents have parental rights as below:**

NAME …………………………….…………………………………………….. Relationship …………………………………

NAME …………………………………………….…………………………….. Relationship …………………………………

**I confirm that only I have parental rights as below:**

NAME …………………………………………….…………………………….. Relationship …………………………….

**Acceptable Behaviour Contract**

**Responsibility and Rights – A Patient Undertaking**

|  |  |
| --- | --- |
| **Your Rights** | **Your Responsibilities** |
| St David’s Practice and their staff owe to me, as a patient, a duty of care and aim to provide services to meet my needs for healthcare and treatment at all times. | I will not behave in any way, which can be considered to be violent or abusive. |
| St David’s Practice and their staff aim to provide health services that are sympathetic to my individual needs within the resources which the ABUHB/Primary Care Independent Contractor has available. | **Violence** includes any incident where the St David’s Practice and their staff, fellow patients and their carers are abused, threatened or assaulted in circumstances related to their work. An act of violence may involve an explicit challenge to the safety, well being or health of any member of ABUHB staff, St David’s Practice and their staff or other patients. Violent behaviour may include verbal abuse, racial or sexual harassment, threats of injury, abuse of alcohol or drugs, destruction of NHS property, as well as physical acts of violence. |
| The St David’s Practice and their staff are expected to treat me with courtesy and respect | **I will treat** the St David’s Practice and their staff, fellow patients and their carers and visitors politely and with respect at all times. |
| The St David’s Practice and their staff want to deliver appropriate and effective healthcare and treatment to me. | **I will not consume alcohol or take any form of non-prescribed medication or drugs whilst on NHS premises.** |
| The St David’s Practice and their staff will only restrict or withdraw my rights to care in exceptional circumstances when I have failed to comply with any of my responsibilities in a manner which is deemed acceptable. | I accept and understand that the St David’s Practice is obliged to provide a safe and secure environment for all its staff and to care for their health and safety. I accept and understand that no member of the St David’s Practice team has to jeopardise their safety in providing me with care. |

I confirm that I understand that if my behaviour has been unacceptable and if I do not comply with my responsibilities

as a patient, then this can result in the withdrawal of my rights as a patient, and I can lose my right to receive mainstream NHS Primary Care Services.

|  |  |
| --- | --- |
| ***Signature of Patient*** |  |
| Print Name (Block Capitals) |  |
| Date: |  |
| ***Verifying Staff Member-Name:*** |  |
| ***Proof of Address used:*** |  |
| ***Date:*** |  |