

# Ampleforth & Hovingham Surgeries

## Patient Registration Form

Please provide a form of ID (which shows your full name and date of birth, it does not need to be photographic) with this registration form. The surgery will take a photocopy for registration purposes only; it will NOT be kept on file.

For children under 16 this form must be completed by the **resident parent** only.

### 1) PATIENT DETAILS

NHS Number:	Date of Birth:
Title: Mr / Mrs / Ms / Miss / Other:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Surname:	Previous Surname(s):
Forenames:	Known as name:
Current Address:	
Town:	Post Code:
Tel No:	Mobile No:
Email Address: (the surgery will send a verification email, please respond to this email to confirm receipt)	
Previous Address (if applicable):	
Place of birth (town/country):	Occupation:
Previous GP and Surgery Address:	

### 2) EHNIC ORIGIN

<p><b>White</b></p> <p><input type="checkbox"/> British</p> <p><input type="checkbox"/> Irish</p> <p><input type="checkbox"/> Any other White background</p> <p><b>Mixed</b></p> <p><input type="checkbox"/> White and Black Caribbean</p> <p><input type="checkbox"/> White and Asian</p> <p><input type="checkbox"/> White and Black African</p> <p><input type="checkbox"/> Any other mixed background</p> <p><b>Asian or Asian British</b></p> <p><input type="checkbox"/> Indian</p> <p><input type="checkbox"/> Bangladeshi</p> <p><input type="checkbox"/> Pakistani</p> <p><input type="checkbox"/> Any other Asian background</p>	<p><b>Black or Black British</b></p> <p><input type="checkbox"/> Caribbean</p> <p><input type="checkbox"/> African</p> <p><input type="checkbox"/> Any other Black background</p> <p><b>Chinese or other ethnic group</b></p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Any other</p> <p><b>Not stated</b></p> <p><input type="checkbox"/> Not stated</p>
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**3) SPOKEN LANGUAGE**

<input type="checkbox"/> English	<input type="checkbox"/> Other (please state)
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**4) CARE STATUS & DEPENDENCIES**

<input type="checkbox"/> I am a carer of a friend or relative Name and address of patient/relative cared for:
<input type="checkbox"/> I have a carer Name and address of carer:  Name and address of next of kin, if not carer:
<input type="checkbox"/> I have a learning disability
<input type="checkbox"/> I have communication / information needs
Please state any needs you may have:

**5) IF YOU ARE FROM ABROAD**

Your first UK address where registered with a GP:	
If previously resident in UK, date of leaving UK:	Date you first came to live in the UK:
<b>If you are from abroad please provide the surgery with a copy of your vaccination history.</b>	
<input type="checkbox"/> I am a Service (Armed Forces) Dependant My last British Forces Post Office number of base prior to moving to this area:	
<input type="checkbox"/> I am ex Services (Armed Forces) Address before enlisting:	
Date of entering forces:	Date of leaving forces:



## 9) YOUR ELECTRONIC PATIENT RECORD & SHARING INFORMATION

### **Sharing Out**

Do you consent to the information that is recorded about you being made available to other NHS care services that care for you and also use SystemOne (the surgery computer system)?

- Yes  
 No

Signature :

### **Sharing In**

Do you consent to allow Ampleforth and Hovingham Surgeries to view information about you that has been recorded at other services where you also receive care?

- Yes  
 No

Signature :

## 10) SUMMARY CARE RECORD

If you do not complete this section we will assume you want a Summary Care Record.

I have read the information provided about the Summary Care Record (SCR) and wish to **opt out**.

Signature:

Date:

## 11) NHS ORGAN DONOR REGISTRATION

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

- Any of my organs and tissue, or  
 Kidneys  Heart  Liver  Corneas  Lungs  Pancreas

Signature:

Date:

For more information please visit the website [www.organdonation.nhs.uk](http://www.organdonation.nhs.uk).

## 12) CONTACT DETAILS

I agree that it is my responsibility to notify the surgery of any changes in contact details including address and telephone numbers.

I agree to being contacted by:  Text Message  Email  Neither

Signature:

Date: