Welcome to your Co-operative Medical Care

PRIMARY

Patient Registration Form

Individual patient registration forms must be completed for each adult and child over the age of 16. If you are the parent or legal guardian of any child under the age of 16 please complete Appendix A to this registration form

Preferred Surgery					
St Helier, 41 David Place		St Peter, Grand Marche St Peter		St Clement, New Era Health Centre	

1. Patient Information					
Title:	**Mr / Mrs / Miss / Ms /**	Home Telephone:			
Forename(s):		Mobile Telephone:			
Surname:		Work Telephone:		Ext:	
Previous Name(s):		Email Address:			
Known As:		JSY Health Insurance No:			
Date of Birth:		Resident in Jersey Since:			
Country of Birth:		First Language: If not English			
Reason For Registering:	☐ Transferring from another Jersey GP ☐ Re-Registering with GP Surgery ☐ New to Jersey				
Co-operative Society Share Number					

2. Home Address and Emergency Contact Information			
Current Home Address:		Emergency Contact:	
		Relationship to Contact:	
		Daytime Telephone:	
		Address:	
Post Code:			

3. Previous Home Address (If less than three years at the current home address)			
Previous Home Address (2):		Previous Home Address (3):	
Date From / To:	/	Date From / To:	/

4. Private Medical Insurance and Current Employer Information (The Patient is responsible for making all claims with their insurer)			
Insurer:		Policy/Scheme Number:	
Current Employer:			

5. Patient ID Confirmation	
Please provide the following documents / information: ☐ Photographic ID (e.g. Passport / Driving Licence) ☐ Proof of home address not more than 3 months old (e.g. Utility Bill / Bank Statement)	*For Practice Use Only* Seen By:

6. Patient Medical History

Have you ever had any of the following		**Please Tick**	**If answered 'yes' please give details.**
1	Epilepsy, fits, blackouts, fainting turns or unexplained loss of consciousness?	☐ Yes ☐ No	
2	Vertigo, dizziness, giddiness, problems with balance?	☐ Yes ☐ No	
3	Recurrent headache or migraine?	☐ Yes ☐ No	
4	Diseases of the nervous system e.g. neuritis, stroke, multiple sclerosis?	☐ Yes ☐ No	
5	Chest pain, angina, heart disease or breathlessness?	☐ Yes ☐ No	
6	Any visual defect e.g. scotoma, blindness in one eye, reduced visual field, blurred vision, coloured blind?	☐ Yes ☐ No	
7	Raised or low blood pressure?	☐ Yes ☐ No	
8	Any blood disorder?	☐ Yes ☐ No	
9	Asthma, bronchitis, emphysema, pneumonia or any other lung disease?	☐ Yes ☐ No	
10	Jaundice or any form of hepatitis or other liver problem?	☐ Yes ☐ No	
11	Any kidney or bladder conditions?	☐ Yes ☐ No	
12	Arthritis, gout, chondromalcia patellae or rheumatism?	☐ Yes ☐ No	
13	Any metabolic disorder including diabetes, thyroid and adrenal gland disease?	☐ Yes ☐ No	
14	Psoriasis, eczema, allergic skin rash or other skin disorder?	☐ Yes ☐ No	
15	Any infectious diseases?	☐ Yes ☐ No	
16	Anxiety/depression, mental breakdown or stress related problems?	☐ Yes ☐ No	
17	Sleep related issues?	☐ Yes ☐ No	
18	Substance misuse (e.g. drugs, steroids)?	☐ Yes ☐ No	
19	Any allergies including hayfever?	☐ Yes ☐ No	
20	Any malignancies or cancers?	☐ Yes ☐ No	
21	Any operations or surgical procedures?	☐ Yes ☐ No	
22	Ear or hearing problems?	☐ Yes ☐ No	
23	Any other medical condition?	☐ Yes ☐ No	
24	Have you ever consulted an orthopaedic surgeon, chiropractor, osteopath or physiotherapist?	☐ Yes ☐ No	
25	Current treatment. Are you currently attending a hospital/GP for treatment or waiting for an appointment?	☐ Yes ☐ No	

7. Other Medical History

Smoking History. Do you or have you ever smoked? ☐ Yes ☐ No

If Yes how much do you smoke per week: How long have you smoked for? When did you give up?

What is your average intake of alcohol per week in units?: Units

(Pint of Regular Beer = 1 Unit / Glass of Wine = 2 Units / Single Measure of Spirits = 1 Unit / Bottle of Wine = 9 Units)

Do you currently take any medication?: ☐ Yes ☐ No

If Yes please provide details:

Female Patients: over 18 years of age;	Date of last cervical smear test: Result: Date of last mammogram if carried out: Result:

Please give further information that you feel may be relevant to your medical history.

8. Family Medical History

Family Member	Age / Deceased	Heart Disease	Hypertension	Diabetes	Psychiatric disease	Cause of Death
Father		☐	☐	☐	☐	☐
Mother		☐	☐	☐	☐	☐
Brother(s)		☐	☐	☐	☐	☐
Sister(s)		☐	☐	☐	☐	☐
Child 1		☐	☐	☐	☐	☐
Child 2		☐	☐	☐	☐	☐
Child 3		☐	☐	☐	☐	☐
Child 4		☐	☐	☐	☐	☐

9. Social Activities

Exercise taken on a normal weekly basis	None	Less than 1 Hour	1-3 Hours	Above 3 Hours
Physical exercise such as swimming, jogging, sports, gym workout	☐	☐	☐	☐
Cycling including to work and leisure time	☐	☐	☐	☐
Walking including to work and leisure time	☐	☐	☐	☐
Gardening/DIY	☐	☐	☐	☐
Which sports or other exercises do you do?				
How would you describe your walking pace?	☐ Slow ☐ Steady ☐ Brisk ☐ Fast			

10. Previous/Existing GP Information			
GP Name:		Telephone Number:	
Address:			
Reason for leaving:			

12. Health Insurance Fund Status (Please tick relevant box)	
Account Status:	☐ HIO ☐ HMA ☐ Private

13: Patient Declaration and Personal Data Statement

Your personal information:

The information collected on this application form will be used by Co-operative Medical Care (hereafter the 'Practice') for the purposes of healthcare related services and practice administration.

Personal data relating to you will be retained by the Practice for the purposes of providing you with medical and healthcare related services both in the Practice and where appropriate at the premises of other healthcare providers. This may require your personal data including relevant details of your medical history to be shared with other healthcare providers for the purpose of referrals and for other lawful purposes related to the Practice procedures.

Your declaration to us:

- I understand that the Practice has the right to accept or decline my registration application at any time.
- I understand that by attending a consultation with a GP or other healthcare professional of the Practice I accept the Practice terms of service and fee schedule issued and displayed in the Practice premises and as amended from time to time.
- I hereby agree to pay the consultation fee prior to seeing a GP or other healthcare professional of the Practice and agree to pay all treatment given by the Practice at the time of the treatment thereafter. I expressly consent that prior to accepting any credit arrangement from the Practice, where appropriate a credit reference check may be taken with an authorised credit reference agency and/or my previous medical practice(s).
- I give my express permission for the Practice to request information including my medical records from my previously registered GP and I agree to reimburse the Practice for all charges and disbursements relating thereto for being provided with such information.
- I confirm that all the information I have given in this registration form is accurate to the best of my knowledge. Furthermore I understand it is my responsibility to advise the Practice in writing of any changes made in respect of my personal information.

Signed:	Print Name:	Dated:

For Practice Use Only	Received By:	On System By:	EMIS Number:
Past medical records requested*		Requested By:	
Other GP Informed of Registration:		Informed By/Date:	

- *Send copy of Page 4 section 13 (signed) to existing GP as authorisation to release medical records to the Practic.e*
- *Individual Form Appendix A to be completed for each child under age of 16*
- *Separate registration forms to be used for visitors or secondary users of the practice.*