Dear New Patient

Welcome to Portsdown Group Practice and thank you for choosing to register with us.

Our practice exists to administer a good level of medical care to all patients who are registered with the practice and our aim is to provide an effective and helpful service. We offer a variety of special clinics and we stock leaflets and booklets on a number of topics including medical conditions, self-help etc. The surgery will liaise on your behalf with hospitals and community care. This information is also available via our website – www.portsdowngrouppractice.co.uk and our practice leaflet (please ask at reception if you would like a leaflet)

As a new patient we would ask that you complete our New Patient Questionnaire fully as this provides us with the information to arrange for your medical records to be transferred to us as well as giving us the opportunity to find a little bit about your medical background. It would be helpful if you could provide photographic proof of ID (e.g. passport or a UK photo driving licence) and proof of residency (e.g. current utility bill, recent bank statement or letter from host family/college). Please note your registration cannot be accepted until the forms are completed in full, with all requested details confirmed. All information provided is treated in the strictest confidence.

We operate an appointment system where we will try to offer an appointment with the next available healthcare professional. We recognise that this can sometimes cause problems for those patients who wish to book appointments with a specific GP; however we feel that this is the best approach under the current nationally directed guidelines. Please remember that if you need to see the doctor on an urgent basis then we will always try to accommodate you, however do not be offended if the Receptionist asks you when the problem started and the nature of the problem. They have been instructed to do so by the doctors and it is not meant to be offensive in any way, it just helps us to help you. You are able to pre-book routine appointments with other members of staff i.e. Practice Nurses and Healthcare Assistants.

The staff and doctors aim to be helpful, courteous and fair at all times, so please do not hesitate to ask a member of staff for help should the need arise. However, from time to time we may not always get it right and if you are unhappy with the service or have any suggestions for improvements, please do not hesitate to contact me or one of the Surgery Team Leaders and we will be pleased to help in any way to resolve the problem.

We do our utmost to provide an excellent service to patients within our financial parameters but, if there is anything that you feel we could be doing better please let us know. We are able to assist patients by escorting them to and from their consultation if appropriate. Patients who are registered hard of hearing are welcome to request appointments via our online service or fax machine.

We hope that you will be happy with the service you receive from us and we look forward to a happy patient/practice relationship.

Yours faithfully

Carly Darwin
Operations Manager

Head Office
Kingston Crescent Surgery
92 Kingston Crescent
North End
Portsmouth
PO2 8AL

Tel No: 02392 009191

PERSONAL DETAILS:				
Title				
Family Name				
Given Name				
Middle Name(s)				
Known As				
Previous Family Name (where applicable)				
Date of Birth				
Town & Country of Birth				
NHS Number				
Gender				
Marital Status				
Ethnicity	☐ British ☐ Chinese ☐ Other Asian ☐ Pakistani	☐ African ☐ Indian ☐ Other Black ☐ W&B African	☐ Bangladeshi ☐ Irish ☐ Other Mixed ☐ W&B Caribbean	☐ Caribbean ☐ Other White ☐ White Asian ☐ Refuse to Divulge
Main Language				
Interpreter Required?	☐ Yes	☐ No		

HOME ADDRESS:	
House Name/Flat No.	
Number & Street	
Locality	
Town	
County	
Postcode	
CONTACT DETAILS:	
Home Telephone	
Work Telephone	
Mobile Telephone	
Email Address	
PATIENT CONTACTS:	
Next of Kin	
Relationship	
Telephone Number	
PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING:	

Branch Surgeries

Cosham Park House Surgery
Cosham Park House Cosham
Park Avenue
Cosham
PO6 3BG

Tel No: 02392 009191

Crookhorn Surgery
Crookhorn Lane
Waterlooville
PO7 5XP

Tel No: 02392 009191

Heyward Road Surgery
3 Heyward Road
Southsea
PO4 0DY

Tel No: 02392 009191

Paulsgrove Surgery
194 Allaway Avenue
Paulsgrove
PO6 4HJ

Tel No: 02392 009191

Somerstown Health Centre
Tyseley Road
Southsea
PO5 4EZ

Tel No: 02392009191

Website: www.portsdowngrouppractice.co.uk Email: Portsdown.group@nhs.net

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Previous address in the UK			
Name & Address of last GP			
Where were you last treated?	(e.g. GP surgery, walk-in centre, A&E etc)		
IF YOU ARE FROM ABROAD:			
First UK address where registered with a GP			
If previously resident in UK date of leaving;			
Date you first came to live in the UK			
IF YOU ARE RETURNING FROM THE ARMED FORCES:			
Are you a veteran?	☐ YES ☐ NO (MINIMUM 1 DAYS SERVICE IN FORCES)		
Address before enlisting			
Service or Personnel no;			
Enlistment Date		Date of Leaving	
CARERS GROUP:			
Are you a carer?	☐ YES	☐ NO	
(If yes) I care for (name):			
Relationship to you:			
The person I care for has:	☐ Dementia	☐ Physical Disability	☐ Mental Illness ☐ Chronic Disease

MEDICAL HISTORY:

Please tick all current or past illnesses/operations including dates where possible:

☐ Heart Disease / Angina	☐ Diabetes	☐ Epilepsy
☐ High Blood Pressure	☐ Stroke/TIA	☐ COPD
☐ Asthma	☐ Cancer	☐ Hypothyroidism
☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Dementia
☐ High Cholesterol	☐ Other (please state):	

Do you have any Allergies? ☐ YES - Please state: ☐ NO
(e.g. antibiotics, food, bee sting, latex)

Immunisations; If known, please circle the immunisation received and complete the date if known;

	Date Received		Date Received
☐ Pneumococcal		☐ Polio	
☐ Tetanus		☐ Yellow Fever	
☐ Typhoid		☐ Hepatitis B	
☐ Hepatitis A		☐ MMR	

LADIES: Are you currently Pregnant? ☐ YES ☐ NO

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Cosham Park House Cosham
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Cosham
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Tel No: 02392 009191

Crookhorn Surgery
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PO7 5XP
Tel No: 02392 009191

Heyward Road Surgery
3 Heyward Road
Southsea
PO4 0DY
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Paulsgrove Surgery
194 Allaway Avenue
Paulsgrove
PO6 4HJ
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If you are pregnant please provide estimated delivery date:

HEALTH INFORMATION:

Weight (Kgs)		Height (metres)	

Smoking Status: (please tick one box only)

☐ I am a Smoker

(For help to stop smoking phone 0800 007 6653 or visit ww.nhs.uk/smokefree)

☐ I have never smoked ☐ I am an ex-smoker - Date quit:

Drinking:

Number of Alcohol units consumed per week;	

Please complete the following questions;

(Alcohol 'FAST' screening test) **Screening test declined** ☐

Scoring:	0	1	2	3	4	T
How often do you have 8 (Men) or 6 (Women) or more drinks one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your score is 2,3 or 4:						
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/clinician been concerned about your drinking/advised you to cut down?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
					Total	

CURRENT MEDICATION:

If you have a repeat medication slip from your previous GP please attach to this form.

Electronic Prescription Service: The practice can now send your prescription to your preferred pharmacy electronically. If you have previously nominated a pharmacy in another area and you now wish to change to a local pharmacy, please inform us of your new preferred pharmacy:	

PRACTICE SERVICES/GROUPS:

Would you be interested in joining the Practice Patient Participation Group?	☐ YES	☐ NO
We will register you for online services automatically. Do you wish to **opt out**? (e.g. Online prescriptions, appointment booking, view summary care record)	☐ YES	☐ NO

OTHER INFORMATION/PATIENT CONFIRMATION:

Accessible Information: Please let us know if you would like to receive information from us in an alternative format, e.g. Large Font, Braille, Easy read or audio and we will do our best to accommodate your request.	

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Declaration: In accordance with the Data Protection Act, the Practice needs consent from any Patient for us to leave a message, send a text or information regarding their medical treatment. By providing the information on this form you are consenting to be contacted about your medical needs by the practice.
If any of the details on this form change in the future please inform us.

Signed:	Date:

Should you require any further information about the Practice please refer to the Practice Website: www.portsdowngroupppractice.co.uk or speak to Reception.

Data Sharing: some organisations utilise the same clinical system as the practice. By sharing in/out this will enable them to access your medical records, and for us to see a summary of any consultations they have with you immediately. Please see our website or ask Reception for further details if required

☐ I wish to share my data with other organisations who may provide me with medical care

☐ I wish to opt out of data sharing (this means your data will not leave the practice)

NHS DONOR REGISTRATION:

I wish to register my details on the NHS Organ donor &/or the NHs Blood Donor register(s) as someone whose organs/tissue may be used for transplantation after my death &/or someone who may be contacted and would be prepared to give blood.

I would like to donate: (Please tick all boxes that apply)

☐ Any of my organs & tissue **or;**	☐ Any part of my body **or;**	
☐ Heart only	☐ Liver only	☐ Corneas only
☐ Kidneys only	☐ Lungs only	☐ Pancreas only
I would like to join the Blood donor register;	☐ Yes	☐ No
I have given Blood in the last 3 years;	☐ Yes	☐ No
Signature confirming consent/ agreement of items ticked above;		

SUPPLEMENTARY QUESTIONS:

Anybody in England can register with a GP practice and receive free medical care from that practice. However if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some service, such as diagnostic tests of suspected infectious disease and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges. More information can be given on request.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the

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purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.
Please tick one of the following boxes:
☐ I understand that I may need to pay for NHS treatment outside of the GP practice
☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested.
☐ I do not know my chargeable status

COMPLETE THIS SECTION IF YOU LIVE IN ANOTHER EEA COUNTRY, OR HAVE MOVED TO THE UK TO STUDY OR RETIRE, OR IF YOU LIVE IN THE UK BUT WORK IN ANOTHER EEA MEMBER STATE. DO NOT COMPLETE THIS SECTION IF YOU HAVE AN EHIC ISSUED BY THE UK.

DO YOU HAVE A NON-UK EHIC OR PRC?	☐ YES ☐ NO	**IF YES, PLEASE ENTER DETAILS FROM YOUR EHIC OR PRC BELOW**

COUNTRY CODE:	
NAME:	
GIVEN NAMES:	
DATE OF BIRTH:	
PERSONAL IDENTIFICATION NUMBER:	
IDENTIFICATION NUMBER OF THE INSTITUTION:	
IDENTIFICATION NUMBER OF THE CARD:	
EXPIRY DATE:	

PRC VALIDITY PERIOD FROM:	DD MM YY	**TO:**	DD MM YY

PLEASE TICK IF YOU HAVE AN S1 (E.G. YOU ARE RETIRING TO THE UK OR YOU HAVE BEEN POSTED HERE BY YOUR EMPLOYER FOR WORK, OR LIVE IN THE UK BUT WORK IN ANOTHER EEA MEMBER STATE) ☐

By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data, GP appointment data and S1 (if appropriate) will be shared with NHS secondary care (hospitals), NHS Digital and the DWP solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

SIGNED:	**PRINT NAME:**	**DATE:**

RECEPTION ONLY:

Type of ID Seen:	1.			2.	
GP Allocated:	☐ YES	☐ NO	Patient informed:	☐ YES	☐ NO
PIN document for Online access printed/given to patient				☐ YES	☐ NO
Actions completed & ID Seen by (initials):					