## **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:	☐ Male ☐ Female
Surname:	Previous Surname(s):
Forenames:	Known as name:
Current Address:	1
Town:	Post Code:
Tel No:	Mobile No:
Email Address:	
(the surgery will send a verification email, please response	nd to this email to confirm receipt)
Previous Address (if applicable):	
Place of birth (town/country):	Occupation:
	·
Previous GP and Surgery Address:	
2) EHNIC ORIGIN	
White  ☐ British	Black or Black British  ☐ Caribbean
☐ Irish	☐ African
☐ Any other White background	☐ Any other Black background
,	,
Mixed	Chinese or other ethnic group
☐ White and Black Caribbean	Chinese
☐ White and Asian	☐ Any other
☐ White and Black African	
☐ Any other mixed background	Not detail
Acien en Acien Dritich	Not stated
Asian or Asian British  ☐ Indian	□ Not stated
☐ Bangladeshi☐ Pakistani	

☐ Any other Asian background

3) SPOKEN LANGUAGE			
☐ English	☐ Other (please state)		
4) CARE STATUS & REPENDENCIES			
4) CARE STATUS & DEPENDENCIES  □ I am a carer of a friend or relative			
Name and address of patient/relative cared	d for		
Traine and address of patient, relative dares			
☐ I have a carer			
Name and address of carer:			
Name and address of next of kin, if not carer:			
☐ I have a learning disability			
☐ I have communication / information ne	eds		
Please state any needs you may have:			
5) IF YOU ARE FROM ABROAD			
Your first UK address where registered with	n a GP:		
If you is all you'dead in the date of the in-	THE DATE OF COLUMN TO SERVICE THE THE		
If previously resident in UK, date of leaving	UK: Date you first came to live in the UK:		
If you are from abroad please provide the surgery with a copy of your vaccination history.			
☐ I am a Service (Armed Forces) Dependant			
My last British Forces Post Office number of base prior to moving to this area:			
☐ I am ex Services (Armed Forces)			
Address before enlisting:			
Date of entering forces:	Date of leaving forces:		

6) PARENT/GUARDIAN DETAILS (For patients under 16 only)			
Date of Birth:	☐ Male ☐ Female		
Surname:	Previous Surname(s):		
Forenames:	Title: Mr / Mrs / Ms / Miss / other:		
Current Address:			
Town:	Post Code:		
Tel No:	Mobile No:		
Relationship to patient:			
Are year the managet/arrayadism was interested at this arraya	v2 □ Vee □ Ne		
Are you the parent/guardian registered at this surger	y? 🗆 Yes 🗆 No		
Are you the resident Parent? ☐ Yes ☐ No			
Do you have parental responsibility? ☐ Yes ☐ No			
The surgery will share your child's clinical record with	h the Health visitors & Healthy child team.		
7) DISPENSING			
If you live more than one mile from a pharmacy, Amp normally dispense your medication.	leforth and Hovingham Surgeries would		
If you do not wish the surgery to dispense your medi	ration please tick and sign the statement below		
If you do not wish the surgery to dispense your medication please tick and sign the statement below.			
Ampleforth and Hovingham Surgeries.  Signature:			
O) DECLI AD MEDICATION / Disease previde very pre-	agricultura light if you have are a		
8) REGULAR MEDICATION (Please provide your pre	Dose Frequency		
Name of Medication	2000 Hequelloy		

## 9) YOUR ELECTRONIC PATIENT RECORD & SHARING INFORMATION

Charles Out			
Sharing Out			
Do you consent to the information that is recorded abo	ut you being made available to other NHS		
care services that care for you and also use SystmOne (the surgery computer system)?			
☐ Yes			
	Signature :		
□ No			
Sharing In			
	rgeries to view information about you that		
Do you consent to allow Ampleforth and Hovingham Surgeries to view information about you that			
has been recorded at other services where you also reco	eive care:		
☐ Yes			
□ No	Signature :		
10) SUMMARY CARE RECORD			
If you do not complete this section we will assume you w	vant a Summary Care Record		
ii you do not complete this section we will assume you w	valit a Sullillary Care Necold.		
I have read the information provided about the Summar	y Care Record (SCR) and wish to <b>opt out.</b>		
•	, , , ,		
Signature:	Date:		
Signature.	Date.		
11) NHS ORGAN DONOR REGISTRATION			
Lorent to an eleterate details on the NUIC Orean Description	-i-t		
I want to register my details on the NHS Organ Donor Re			
be used for transplantation after my death. Please tick t	he boxes that apply.		
And of any areas and there are			
Any of my organs and tissue, or	_		
☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs	☐ Pancreas		
Signature:	Date:		
For more information please visit the website www.orga	ndonation pho uk		
For more information please visit the website www.organdonation.nhs.uk.			
12) CONTACT DETAILS			
Lagran that it is not recognishible, to notify the access of	form about the contract details in alreding		
I agree that it is my responsibility to notify the surgery of	any changes in contact details including		
address and telephone numbers.			
Lagran to being contacted by Tayt Massage	il D Noither		
I agree to being contacted by: ☐ Text Message ☐ Ema	ii 🗀 iveither		
Signature:	Date:		