

# **Riverside Medical Practice**

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[riversidemedicalpractice.com](http://riversidemedicalpractice.com)

## **New Patient Registration**

### **Children's Registration**

**Please complete the details below:**

Forename: \_\_\_\_\_ Surname: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Postcode: \_\_\_\_\_

Parent / Carers Home Telephone Number \_\_\_\_\_

Parent / Carers Mobile Telephone Number \_\_\_\_\_

Do you have a preferred method of contact for us to use? \_\_\_\_\_

Does the registering child have any communication difficulties that we need to be made aware of?  
(For example do they have difficulty hearing or require an interpreter?)

**If the registering child or family have previously been known or they are currently known to Children's Services, please ask reception for the additional 'Looked after Children' registration form.**

**Please tick the registering child's ethnic group below:**

<input type="checkbox"/> <b><u>White</u></b> English, Welsh, Scottish, Northern Irish or British / Irish / Gypsy or Irish Traveller / Any other White Background.	<input type="checkbox"/> <b><u>Mixed or Multiple ethnic groups</u></b> White and Black Caribbean / White and Black African / White and Asian / Any other Mixed or Multiple ethnic background	<input type="checkbox"/> <b><u>Asian or Asian British</u></b> Indian / Pakistani / Bangladeshi / Chinese / Any other Asian background	<input type="checkbox"/> <b><u>Black, African, Caribbean or Black British</u></b> African / Caribbean / Any other Black, African or Caribbean background	<input type="checkbox"/> <b><u>Other Ethnic Group</u></b> Arab / Any other ethnic group
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Please sign to confirm that you have received and understood the Privacy Notice (enclosed in the practice leaflet).

<b><u>Signature</u></b>	<b><u>Relationship to the patient:</u></b>	<b><u>Date</u></b>	
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## Patient's details

Please complete in BLOCK CAPITALS and tick ☒ as appropriate

<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	Surname
Date of birth				First names
NHS No.				Previous surname/s
<input type="checkbox"/> Male <input type="checkbox"/> Female				Town and country of birth
Home address				
Postcode				
Telephone number				

## Please help us trace your previous medical records by providing the following information

Your previous address in UK	Name of previous GP practice while at that address
	Address of previous GP practice

## If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving	Date you first came to live in UK
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## Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:

	Postcode
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Service or Personnel number: Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

## If you need your doctor to dispense medicines and appliances\*

<input type="checkbox"/> I live more than 1.6km in a straight line from the nearest chemist	*Not all doctors are authorised to dispense medicines
<input type="checkbox"/> I would have serious difficulty in getting them from a chemist	

<input type="checkbox"/> Signature of Patient	<input type="checkbox"/> Signature on behalf of patient	Date
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## 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.

<input type="checkbox"/> Any of my organs and tissue or
<input type="checkbox"/> Kidneys <input type="checkbox"/> Heart <input type="checkbox"/> Liver <input type="checkbox"/> Corneas <input type="checkbox"/> Lungs <input type="checkbox"/> Pancreas

Signature confirming my consent to join the NHS Organ Donor Register Date

Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit [www.organdonation.nhs.uk](http://www.organdonation.nhs.uk) or call 0300 123 23 23 to register your decision.

## NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years

Signature confirming my consent to join the NHS Blood Donor Register Date

My preferred address for donation is: (only if different from above, e.g. your place of work) Postcode:

All blood types are needed, especially O negative and B negative. Visit [www.blood.co.uk](http://www.blood.co.uk) or call 0300 123 23 23.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

## To be completed by the GP Practice

Practice Name

Practice Code

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

*I declare to the best of my belief this information is correct*

Practice Stamp

Authorised Signature

Name

Date / /

**SUPPLEMENTARY QUESTIONS QUESTIONS** - These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

### PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

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 services, such as diagnostic tests of suspected infectious diseases 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 on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

**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 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:**

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ 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

c) ☐ I do not know my chargeable status

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.

**A parent/guardian should complete the form on behalf of a child under 16.**

<b>Signed:</b>		<b>Date:</b>	DD MM YY
<b>Print name:</b>		<b>Relationship to patient:</b>	
<b>On behalf of:</b>			

**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.**

### NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a <u>non-UK</u> EHIC or PRC?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	If yes, please enter details from your EHIC or PRC below:
<p><i>If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.</i></p>	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
	PRC validity period (a) From:	DD MM YYYY

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 you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff**

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

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.