PATIENT REGISTRATION FORM:
ADULT AGED 16 AND OVER

Documents Required
• ID • Proof of Address • Green Health Card

Clifden SURGERY

Individual patient registration forms must be completed for each adult and young person over the age of 16.
Please complete clearly all relevant sections of this registration form.

ADULT: PRIMARY ①

1. Patient Information ☐				
Title:	**Miss / Mr / Mrs / Ms / Mstr / Mx /**	Gender Identity:	☐ Female ☐ Male ☐ Trans ☐ Other	
Family Name:		Marital Status:	☐ Single ☐ Married ☐ Civil Partnership ☐ Separated ☐ Divorced ☐ Other	
Given Name(s):		Ethnicity: Select A and B	A: ☐ White ☐ Black ☐ Asian ☐ Mixed ☐ Other B: ☐ British ☐ European ☐ Other	
Known As:		First Language: If not English		
Previous Family Name:		Resident Since: Month/Year	/	
Date of Birth:		Jersey SS Health Card No:		Seen By:
Reason for Registering with the Practice:	☐ Transferring from another Jersey GP Practice ☐ Re-Registering with GP Practice ☐ New Resident in Jersey			
ID Confirmed:	☐ Yes ☐ No	Photo ID Type: (Passport / Driving Licence)		Seen By:

2. Home Address and Contact Information (For ID purposes Utility Bill/Bank Statement dated within 3 months is valid) ☐					
Current Home Address (1):		Home Telephone:			
		Work Telephone:			
		Mobile Telephone:			
		Personal Email Address:			
Post-Code:		Address Confirmed: Dated within 3 months of issue	☐ Yes ☐ No	Doc. Type:	Seen By:
Access Information: (for impaired patient visits)					

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. Emergency Contact/Next of Kin Information ☐			
Title:	**Miss / Mr / Mrs / Ms / Mx /**	Home Address & Post-Code: ☐ Same as Section 2	
Family Name:			
Given Name(s):			
Date of Birth:		Home Telephone:	
Relationship to Patient:		Work Telephone:	
Is this Your Next of Kin	☐ Yes ☐ No	Mobile Telephone:	
Consent for us to Discuss Your Record:	☐ Yes ☐ No	Your Official Carer:	☐ Yes ☐ No

5. Children Aged Under 16 and you are Parent/Legal Guardian (Registrations Form to be completed for all those registering with the practice) ☐		
Child's Full Name:		Date of Birth:
Child's Full Name:		Date of Birth:
Child's Full Name:		Date of Birth:
Child's Full Name:		Date of Birth:

6. Private Medical Insurance and Current Employer Information (The Patient is responsible for making all claims with their insurer) ☐	
Current Employer:	
Insurance Provider:	

7. Previous/Existing GP Information (This will be used to request previous medical record information) ☐			
GP Name:		Telephone Number:	
Address:			
Reason for Transferring:			

8. Patient Declaration, Confidentiality Agreement, Personal Data Statement and Communication ☐

Your Personal Information (Data Protection and Patient Privacy):
The information collected on this application form will be used by **Clifden Surgery** (hereafter the 'Practice') for the purposes of healthcare related services and practice administration. Personal information we hold about you is processed for the purposes of 'Employment and Social Fields' (Article 8) 'Medical Purposes' (Article 15) and 'Public Health' (Article 16) of the Data Protection (Jersey) Law 2018. This may require your personal data including, relevant details of your medical history, to be shared with other approved healthcare providers for the purpose of referrals and for other lawful purposes related to the Practice procedures. Further information on how we hold and process your data can be found in our Data Protection and Patient Privacy Policy.

General Practice Central Services (GPCS):
All Jersey GP Practices and other approved healthcare service providers, such as the out-of-hours doctors, use a central medical records system known as EMIS. This allows access to a 'shared medical record' to ensure that the provider or clinician has immediate up-to-date and accurate information about your health and any current treatment you may be having. You do however have the right to 'opt out' of sharing some or all of your medical records. Please ask us for more information and where appropriate an Opt-in/Out Form for completion. All approved healthcare service providers with authorised access to GPCS have signed strict confidentiality agreements which are bound by the Data Protection (Jersey) Law 2018.

Your Declaration to us:

- I confirm that all the information I have given in this registration form is accurate to the best of my knowledge.
- 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 any incurred service fees from the Practice at the time of attendance or treatment.
- I expressly consent that on registration or 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 any charges and disbursements incurred relating thereto for the Practice being provided with such information.
- I understand it is my sole 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:	EMIS Entered By:	☐ Pre-Registration ☐ Regular ☐ Private	EMIS Number:
Medibooks:	Synchronised:	Billing Pattern:	Alerts Added:
Past medical records requested*	Date:	Requested By:	Received Date:
Other GP Informed of Registration:	Date:	Informed By:	Check Requested:

- *Send copy of Page 2 section 8 (signed) to existing GP as authorisation to release medical records to the Practice and amend EMIS patient type*
- *Individual Form 2 to be completed for each child under age of 16*

Medical History/Assessment Form

Patient Name:		Date of Birth:	

9. Patient Summary Medical History ☐

	Have you ever had any of the following	Please Tick ✓
1	Diseases of the nervous system e.g. neuritis, stroke, multiple sclerosis?	☐ Yes ☐ No
2	Chest pain, angina, heart disease or breathlessness?	☐ Yes ☐ No
3	Raised or low blood pressure?	☐ Yes ☐ No
4	Asthma, bronchitis, emphysema, pneumonia or any other lung disease?	☐ Yes ☐ No
5	Any metabolic disorder including diabetes, thyroid and adrenal gland disease?	☐ Yes ☐ No
6	Please complete the Smoking Status and Alcohol Consumption Questionnaire attached.	☐ Completed

Please provide further information that you feel may be relevant to your current or past medical history:

10. Other Medical History ☐

Allergies: Do you have any known or diagnosed allergies or adverse reactions to drugs, medication or other ☐ Yes ☐ No

If Yes please provide details:

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

If Yes please provide details:

For Female Patients Only :

Cervical Screening (aged 25 and over):
Last Screening Date: Result: Never Screened: ☐

Mammography Screening (aged 50 and over):
Last Screening Date: Result: Never Screened: ☐

11. Your Exercise and 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			

12. Family Medical History (If Known) ☐

Family Member	Age / Deceased	Heart Disease	Hypertension	Diabetes	Cancer	Mental Health	Cause of Death (if known)
Mother		☐	☐	☐	☐	☐	
Father		☐	☐	☐	☐	☐	
Sister		☐	☐	☐	☐	☐	
Sister		☐	☐	☐	☐	☐	
Brother		☐	☐	☐	☐	☐	
Brother		☐	☐	☐	☐	☐	
Child		☐	☐	☐	☐	☐	
Child		☐	☐	☐	☐	☐	

For Practice Use Only	☐ EMIS Shared Record Activated for Health Data	By Staff ID:
EMIS Shared Record Information:	**Health Status, where recorded within the last 12 months:** ☐ Height ☐ Weight ☐ BMI ☐ Blood Pressure **Other Health Data:** ☐ Current Active Problems ☐ Significant Past Problems ☐ Allergies/Adverse Reactions ☐ Childhood Immunisations ☐ Travel/Other Immunisations ☐ Cytology Result ☐ Mammography Result ☐ PSA Result (Males over 50)	

Smoking Status and Alcohol Consumption Questionnaire

Patient Name:		Date of Birth:	

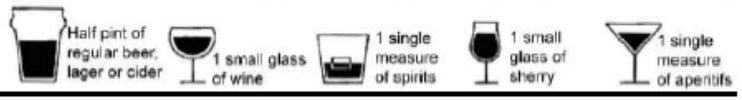
13. Smoking History ☐

What is your current smoking status?

1. ☐ Never Smoked	*Please also complete the 'Other Smoking Information' in section 4 below*	
2. ☐ Ex-Smoker	When did you quit?	Month: Year:
	What products did you smoke?	☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Vape
	If cigarettes, how many did you smoke on an average day?	☐ < 1 ☐ 1-9 ☐ 10-19 ☐ 20-39 ☐ 40+
3. ☐ Current Smoker	What products do you smoke?	☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Vape
	If cigarettes, how many do you smoke per day on average?	☐ < 1 ☐ 1-9 ☐ 10-19 ☐ 20-39 ☐ 40+
	If vaping, do you use both tobacco products and vaping together?	☐ Yes ☐ No
	Have you considered or previously tried quitting?	☐ Yes ☐ No
	What made you start smoking again?	
	Would you like advice on the Help2Quit Stop Smoking service in Jersey?	☐ Yes ☐ No
4. Other Smoking Information	Are there other smokers in your home?	☐ Yes ☐ No
	Do you or other smokers smoke inside your home?	☐ Yes ☐ No
	Are there any persons under the age of 18 in the home who may open to a passive smoking risk in your home?	☐ Yes ☐ No
	If you smoke cannabis or any other products not recorded above, it is advisable to discuss your use confidentially with your GP, so that they can advise you appropriately on any potential smoking risks to you.	

14. Alcohol Consumption ☐

This is one unit of alcohol...



...and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

SCORE

Score from AUDIT- C (other side)

SCORE

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL

TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions