MILLVIEW MEDICAL CENTRE

CONFIDENTIAL REGISTRATION QUESTIONNAIRE

To assist the practice in providing good medical care, please complete the following details and return to Reception with your registration document and proof of identification and address. If you would like to register for online facilities, please ask at Reception.

PERSONAL INFORMATION	
TITLE (please delete as appropriate)	MR/MRS/MS/MISS/ (other)
FIRST NAME(S)	
SURNAME	
DATE OF BIRTH	
TELEPHONE: HOME	
TELEPHONE: WORK	
TELEPHONE: MOBILE	
EMAIL ADDRESS	
ONLINE ACCESS REQUIRED	YES* / NO *(COLLECT FORM)
PERMIT SMS TEXT ALERTS?	YES* / NO (*COLLECT FORM)
CARER?	YES* / NO *(COLLECT FORM)
SUMMARY CARE RECORD OPT-OUT?	YES* / NO (*COLLECT FORM)

MEDICATION INFORMATION (ATTACH LAST REPEAT PRESCRIPTION)

Are you allergic to any medications (e.g. penicillin), please state:

Do you have any allergies (e.g. pollen, eggs), please state:

Are you taking any PRESCRIBED MEDICATIONS/TABLETS at present?

DRUG	STRENGTH (mg)	DOSE

OTHER INFORMATION

So far as you are aware, are you currently on any waiting list within the NHS for any operations or outpatients appointments? **YES/NO**

If yes, please provide the following information if possible: hospital, department, consultant and any operation or procedure awaited (including the hospital number if known):

PLEASE COMPLETE BOTH SIDES

PTO

Thank you very much for your help. We cannot complete your registration until you have attended the surgery for a new patient registration medical and repeat medication appointment.

PLEASE MAKE APPOINTMENT(S) FOR A NEW PATIENT HEALTH CHECK AND A NEW PATIENT REPEAT APPOINTMENT AS SOON AS POSSIBLE.

If you are on any regular repeat medication you are advised that a prescription will not be issued until you have seen a doctor.

The information I have provided is correct and I apply to be included on the list of the Practice. I acknowledge receipt of an offer for medical examination/repeat medication review.

PATIENT PLEASE SIGN BELOW:

Signed:	**Date:**

RECEPTION STAFF CHECK LIST	**COMPLETE**
a. Personal details verified *(e.g. Drivers License/Passport/NHS Card)*	
b. Address details verified *(e.g. Utility Bill)*	
c. Proof of Home Office Work permit if applicable *(Minimum 6 Months)*	
d. Additional forms provided *(Online / SMS / Carers / SCR Opt-out)*	
e. Repeat prescription attached	
f. Dispensing status noted *(As per their address, please refer to map/Dispensary Manager)*	
g. New patient health check booked with Nurse/HCA[1] as appropriate	
h. New patient repeat medication appointment booked if applicable *(KM/VJ/RS)*	
i. New babies – Read code 9344 applied to record	

RECEPTION STAFF MEMBER SIGN BELOW:

Name:	**Signed:**	**Date:**

DISPENSARY STAFF CHECK LIST	**COMPLETE**
a. Dispensing status verified *(As per their address, please refer to map/Dispensary Manager)*	
b. Medication list actioned	

DISPENSARY STAFF MEMBER SIGN BELOW:

Name:	**Signed:**	**Date:**

GP LINKS CHECK LIST	**COMPLETE**
a. New patient details checked and verified including dispensing status	
b. Patients records received from HA	
c. Patient records summarised by HCA	
d. Patient records summarised by GP	
e. Patient records stored *(Heckington / Sleaford)*	
f. Forms scanned to patient record / stored with Lloyd George	
g. Registration complete	

GP LINKS STAFF PLEASE VERIFY DETAILS AND SIGN BELOW:

Name:	**Signed:**	**Date:**

[1] EW for Nurse, LK for HCA where possible

PLEASE COMPLETE BOTH SIDES

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