**NEW PATIENT REGISTRATION FORM**

**\* PLEASE COMPLETE IN CAPITALS \***

**\* BRING 2 FORMS OF ‘ID’ WITH YOU (1 OF WHICH MUST BE PHOTOGRAPHIC, 1 WITH YOUR ADDRESS ON) \***

**The Partners and Staff would like to welcome you to Millview Medical Centre and we are pleased you have chosen to register with us today.**

We strive to ensure our Patients receive excellent care and support and for your convenience we have 2 sites.

**Please ensure you read and complete ALL sections of this form**

 (any missed information may delay your registration process as we will have to contact you to return and complete any missed sections. Nb: please write n/a in any section that is not applicable i.e allergies etc)

**Thank you**

**The Partners & Staff of Millview Medical Centre**

**SHARING OF YOUR HEALTH RECORDS**

Sharing information about your health within different areas of the NHS will help us meet your individual care needs, speed up diagnosis and help to plan services and treatments in your local area. Please tick the boxes below to help us to identify who we can share your health records with:

**SHARING OUT:**

 I CONSENT to the information which is recorded about me on System One (our clinical recording

 system being made available to other NHS Care Services (eg: District Nurses, Physiotherapists etc)

 I DO NOT CONSENT to other Clinicians accessing my medical information

**SHARING IN:**

 I CONSENT to Millview Medical Centre accessing information about me which has been recorded by

 other services which provide my care

 I DO NOT CONSENT to Millview Medical Centre accessing information recorded by other health and

 care professionals

**BEING CONTACTED:**

 I CONSENT to the practice contacting me via TEXT MESSAGE (for the purposes of appointments,

 reminders, health information or Patient’s feedback)

What is your preferred method of contact? TEXT EMAIL LETTER *(Please tick appropriate box)*

I understand that Millview Medical Centre is a Heckington based Surgery with a branch site based in Sleaford and that as a registered Patient I am willing to travel to both sites to access services.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_