ADULT REGISTRATION FORM

Please fill in all the sections below using **BLOCK CAPITALS**

If you need someone to help you complete this form please speak to our reception team.

If you need to add additional pages to this form please attach them to the form and tick this box ☐

All information recorded on these forms will be stored electronically on your medical record.

This information will be strictly confidential and will never be shared without your consent.

FULL NAME:	
DATE OF BIRTH:	
HOME ADDRESS:	
MOBILE NUMBER:	
OTHER NUMBER(S):	
EMAIL ADDRESS:	

By providing a mobile number you agree to be contact via free text messages from the practice. This could be from a clinician or other member of staff and will also include appointment reminders. If you wish to opt out of this please tick this box: ☐

ETHNIC ORIGIN:	☐ British/Mixed British	☐ Irish
	☐ Other White Background	☐ White & Black African
	☐ White & Black Caribbean	☐ Black African
	☐ Black Caribbean	☐ Other Black Background
	☐ Bangladeshi	☐ Indian
	☐ Pakistani	☐ Chinese
	☐ White & Asian	☐ Other Asian Background
	☐ Other Mixed Background	☐ Rather Not Say
	☐ Other (Please Specify)	

RELIGION:		☐ Rather Not Say
MARITAL STATUS:		☐ Rather Not Say
SEXUALITY:		☐ Rather Not Say
GENDER IDENTITY & PREFERRED PRONOUNS		☐ Rather Not Say
SPOKEN LANGUAGE:		
DO YOU REQUIRE AN INTERPRETER?	☐ YES ☐ NO	

ARE YOU A MILITARY VETERAN?	☐ YES ☐ NO

KNOWN DISABILITIES, HEALTH CONDITIONS OR ALLERGIES:			
DO YOU REQUIRE ANY COMMUNICATION SUPPORT?	☐ Sign Language Interpreter	☐ Deaf-Blind Interpreter	
	☐ Advocate	☐ Speech to Text Reporter	
	☐ Other Interpreter/Accessible Support (Please Specify)		
DO YOU HAVE DIFFICULTY READING OR WRITING?	☐ YES ☐ NO	**PLEASE LET THE RECEPTIONIST KNOW HOW YOU WOULD PREFER TO BE CONTACTED**	
ARE YOU REGISTERED DISABLED?	☐ YES ☐ NO	**DO YOU HAVE A CARER?**	☐ YES ☐ NO
CARER NAME:		**CARER CONTACT:**	
DO YOU GIVE CONSENT FOR YOUR CARER TO DISCUSS YOUR MEDICAL RECORD?			☐ YES ☐ NO

ARE YOU A CARER?	☐ YES ☐ NO
WHO DO YOU CARE FOR?	

DO YOU SMOKE?	☐ YES ☐ NO
WOULD YOU LIKE HELP TO QUIT?	☐ YES ☐ NO ☐ NOT APPLICABLE
ARE YOU EXPOSED TO SMOKE AT WORK OR IN YOUR HOME?	☐ YES ☐ NO

ARE YOU ON ANY MEDICATION?	☐ YES ☐ NO
IF YES PLEASE OBTAIN A CURRENT LIST FROM YOUR PREVIOUS GP SURGERY AND ASK THEM TO ORDER ANY REPEAT MEDICATIONS THAT ARE DUE SOON You must bring this with you to your New Patient Health Check appointment with the nurse	

NEXT OF KIN DETAILS

NAME:	
CONTACT NUMBER:	
RELATIONSHIP TO PATIENT:	
CONSENT TO DISCUSS MEDICAL RECORD?	☐ YES ☐ NO

CONTACT PREFERENCE(S):	☐ PHONE ☐ SMS ☐ POST ☐ EMAIL ☐ VIA CARER/NEXT OF KIN

SIGNATURE:	
DATE:	

Please make sure to also sign the purple GMS1 form attached to this registration pack

ACCEPTABLE FORMS OF ID

☐ Passport ☐ Driving License ☐ Birth Certificate

AND

☐Utility Bill ☐ Council Tax Statement ☐ Bank Statement

A copy of these will be taken and stored electronically with your medical record – we will only copy relevant information and once this is scanned to record it will be destroyed confidentially. If you are struggling to provide this information please speak to a member of staff at reception.
For more information regarding our confidentially, dignity, equality or privacy policies please contact Hope Citadel Healthcare CIC via info@hopecitadel.org.uk

NEXT STEPS:

- Once you have handed this to our reception team you will be registered in the next 48 working hours
- You will need to book a new patient medical with our healthcare assistant before you can book routine GP appointments
- If you require an urgent GP appointment before this new patient medical you must phone on the day you require at 8am
- If you do not attend a new patient medical you may be removed from the practice register
- It is your responsibility to keep your contact details up to date to ensure that we are able to contact you when necessary – forms are available at reception to update your details at any time.

FOR OFFICE USE ONLY

TAKEN IN BY		DATE	
ID SEEN/COPIED	☐ YES ☐ NO	NPM DATE	
REGISTRATION DATE		EMIS NUMBER	