

Dear New Patient

**Welcome to Portsdown Group Practice and thank you for choosing to register with us.**

Our practice exists to administer a good level of medical care to all patients who are registered with the practice and our aim is to provide an effective and helpful service. We offer a variety of special clinics and we stock leaflets and booklets on a number of topics including medical conditions, self-help etc. The surgery will liaise on your behalf with hospitals and community care. This information is also available via our website – [www.portsdowngrouppractice.co.uk](http://www.portsdowngrouppractice.co.uk) and our practice leaflet (please ask at reception if you would like a leaflet)

As a new patient we would ask that you complete our New Patient Questionnaire fully as this provides us with the information to arrange for your medical records to be transferred to us as well as giving us the opportunity to find a little bit about your medical background. It would be helpful if you could provide photographic proof of ID (e.g. passport or a UK photo driving licence) and proof of residency (e.g. current utility bill, recent bank statement or letter from host family/college). Please note your registration cannot be accepted until the forms are completed in full, with all requested details confirmed. All information provided is treated in the strictest confidence.

We operate an appointment system where we will try to offer an appointment with the next available healthcare professional. We recognise that this can sometimes cause problems for those patients who wish to book appointments with a specific GP; however we feel that this is the best approach under the current nationally directed guidelines. Please remember that if you need to see the doctor on an urgent basis then we will always try to accommodate you, however do not be offended if the Receptionist asks you when the problem started and the nature of the problem. They have been instructed to do so by the doctors and it is not meant to be offensive in any way, it just helps us to help you. You are able to pre-book routine appointments with other members of staff i.e. Practice Nurses and Healthcare Assistants.

The staff and doctors aim to be helpful, courteous and fair at all times, so please do not hesitate to ask a member of staff for help should the need arise. However, from time to time we may not always get it right and if you are unhappy with the service or have any suggestions for improvements, please do not hesitate to contact me or one of the Surgery Team Leaders and we will be pleased to help in any way to resolve the problem.

We do our utmost to provide an excellent service to patients within our financial parameters but, if there is anything that you feel we could be doing better please let us know. We are able to assist patients by escorting them to and from their consultation if appropriate. Patients who are registered hard of hearing are welcome to request appointments via our online service or fax machine.

We hope that you will be happy with the service you receive from us and we look forward to a happy patient/practice relationship.

Yours faithfully



**Carly Darwin**  
**Operations Manager**

PERSONAL DETAILS:	
Title	
Family Name	
Given Name	
Middle Name(s)	
Known As	
Previous Family Name (where applicable)	
Date of Birth	
Town & Country of Birth	
NHS Number	
Gender	
Ethnicity	<input type="checkbox"/> British <input type="checkbox"/> African <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Caribbean <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Irish <input type="checkbox"/> Other White <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Black <input type="checkbox"/> Other Mixed <input type="checkbox"/> White Asian <input type="checkbox"/> Pakistani <input type="checkbox"/> W&B African <input type="checkbox"/> W&B Caribbean <input type="checkbox"/> Refuse to Divulge
Main Language	
Interpreter Required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
HOME ADDRESS:	
House Name\Flat No.	
Number & Street	
Locality	
Town	
County	
Postcode	
CONTACT DETAILS:	
Home Telephone	
Work Telephone	
Mobile Telephone	
Email Address	
PATIENT CONTACTS:	
Next of Kin	
Relationship	
Telephone Number	

**Branch Surgeries**

Cosham Park House Surgery  
Cosham Park House Cosham  
Park Avenue  
Cosham  
PO6 3BG

Crookhorn Surgery  
Crookhorn Lane  
Waterlooville  
PO7 5XP

Heyward Road Surgery  
3 Heyward Road  
Southsea  
PO4 0DY

Paulsgrove Surgery  
194 Allaway Avenue  
Paulsgrove  
PO6 4HJ

Somerstown Health Centre  
Tyseley Road  
Southsea  
PO5 4EZ

Tel No: 02392 009191

Tel No: 02392 009191

Tel No: 02392 009191

Tel No: 02392 009191

Tel No: 02392009191

Website: [www.portsdowngrouppractice.co.uk](http://www.portsdowngrouppractice.co.uk)

Email: [Portsdown.group@nhs.net](mailto:Portsdown.group@nhs.net)

PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING:			
Previous address in the UK			
Name & Address of last GP			
Where were you last treated?	(e.g. Gp surgery, walk-in centre, A&E etc)		
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 the UK			
CARERS GROUP (YOUNG CARERS):			
Are you a Young Carer?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
(If yes) I care for (name):			
Relationship to you:			
The person I care for has:	<input type="checkbox"/> Dementia	<input type="checkbox"/> Physical Disability	<input type="checkbox"/> Mental Illness <input type="checkbox"/> Chronic Disease
MEDICAL HISTORY:			
<b>If under 5:</b>			
Type of birth (e.g. natural, Caesarean)			
Birth weight (if known)			
Feeding (e.g. breast or bottle)			
Please note all details of children under 5 are passed to the Health Visiting Team for Child Health Surveillance			
Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details: (please continue on separate sheet if needed)			
Condition	Year Diagnosed	Ongoing?	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Do you have any Allergies?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			

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(e.g. antibiotics, food, bee sting, latex)			
<b>If Yes – please state:</b>			
<b>Immunisations;</b>			
If known, please circle the immunisation received and complete the date if known;			
	Date Received		Date Received
Whooping Cough		Polio	
Tetanus		HiB	
Measles		MMR	
BCG (TB)		Meningitis	
Booster: Tetanus		Booster: Polio	
Booster: Diphtheria		Booster: MMR	
<b>HEALTH INFORMATION:</b>			
Weight (st/lbs or Kgs)		Height (ft" or metres)	
<b>CURRENT MEDICATION:</b>			
If you have a repeat medication slip from your previous GP please attach to this form.			
<b>OTHER INFORMATION\PATIENT CONFIRMATION:</b>			
<b>Accessible Information:</b> Please let us know if you would like to receive information from us in an alternative format, e.g. Large Font, Braille, Easy read or audio and we will do our best to accommodate your request.			
<b>Electronic Prescription Service:</b> The practice can now send your prescription to your preferred pharmacy electronically. If you have previously nominated a pharmacy in another area and you now wish to change to a local pharmacy, please inform us of your preferred pharmacy:			
In accordance with the Data Protection Act, the Practice needs consent from any Patient for us to leave a message, send a text or information regarding their medical treatment. By providing the information on this form you are consenting to be contacted about your medical needs. <b><u>If any of the details on this form change in the future please inform us.</u></b>			
Name of Person signing on behalf of patient:			
Relationship to Patient:			

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<b>Signed:</b>	<b>Date:</b>
Should you require any further information about the Practice please refer to the Practice Website: <a href="http://www.portsdowngrouppractice.co.uk">www.portsdowngrouppractice.co.uk</a> or speak to Reception.	
<b>NHS DONOR REGISTRATION:</b>	
I wish to register my details on the NHS Organ donor & \or the NHs Blood Donor register(s) as someone whose organs \tissue may be used for transplantation after my death & \or someone who may be contacted and would be prepared to give blood.	
I would like to donate: (Please tick all boxes that apply)	
<input type="checkbox"/> Any of my organs & tissue <b>or;</b>	<input type="checkbox"/> Any part of my body <b>or;</b>
<input type="checkbox"/> Heart only	<input type="checkbox"/> Liver only
<input type="checkbox"/> Kidneys only	<input type="checkbox"/> Lungs only
	<input type="checkbox"/> Corneas only
	<input type="checkbox"/> Pancreas only
I would like to join the Blood donor register;	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have given Blood in the last 3 years;	<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature confirming consent \ agreement of items ticked above;	
<b>SUPPLEMENTARY QUESTIONS:</b>	
<p>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.</p> <p>Some service, such as diagnostic tests of suspected infectious disease 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 can be given on request.</p> <p>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.</p> <p>Please tick one of the following boxes:</p> <p><input type="checkbox"/> I understand that I may need to pay for NSH treatment outside of the GP practice</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> I do not know my chargeable status</p>	

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<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. <u>DO NOT</u> COMPLETE THIS SECTION IF YOU HAVE AN EHIC ISSUED BY THE UK.</b>					
<b>DO YOU HAVE A NON-UK EHIC OR PRC?</b>			<input type="checkbox"/> YES <input type="checkbox"/> NO		<b>IF YES, PLEASE ENTER DETAILS FROM YOUR EHIC OR PRC BELOW</b>
<b>COUNTRY CODE:</b>					
<b>NAME:</b>					
<b>GIVEN NAMES:</b>					
<b>DATE OF BIRTH:</b>					
<b>PERSONAL IDENTIFICATION NUMBER:</b>					
<b>IDENTIFICATION NUMBER OF THE INSTITUTION:</b>					
<b>IDENTIFICATION NUMBER OF THE CARD:</b>					
<b>EXPIRY DATE:</b>					
<b>PRC VALIDITY PERIOD FROM:</b>	DD MM YY		<b>To:</b>	DD MM YY	
<b>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 LIVE IN THE UK BUT WORK IN ANOTHER EEA MEMBER STATE)</b> <input type="checkbox"/>					
By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data, GP appointment data and S1 (if appropriate) will be shared with NHS secondary care (hospitals), NHS Digital and the DWP solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.					
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.					
<b>SIGNED ON BEHALF OF PATIENT:</b>		<b>PRINT NAME:</b>		<b>DATE:</b>	
<b>RELATIONSHIP TO PATIENT:</b>					
<b>RECEPTION ONLY:</b>					
<b>Type of ID Seen:</b>		1.		2.	
<b>GP Allocated:</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO		<b>Patient informed:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>Actions completed &amp; ID Seen by (initials):</b>					

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