

SPRINGHILL MEDICAL CENTRE

CHILD’S REGISTRATION PACK

**Practice information and opening times**

**Springhill Medical Centre Galley Common**

**Phil Collins Way Valley Road**

**Arley Nuneaton**

**Nr Coventry Warwickshire**

**CV7 8FD (Postal Address) CV10 9NH**

**CV7 8NZ (Postcode for Sat Nav)**

**Tel: 01676 540395 Tel: 02476 397264**

**Monday-Friday 8:30-12:30 &13:30-18:30 Monday-Friday 08:00-11:30 & 13:30-16:30**

**(PLEASE NOTE WE ARE CLOSED BANK HOLIDAYS AT BOTH SURGERIES)**

**We are online at**

[**www.springhillmedicalcentre.co.uk**](http://www.springhillmedicalcentre.co.uk)

**Forms Included in the Registration Pack (In Order)**

**Family Doctor Services Registration:**

This is the purple form attached to your registration pack. This registers you as being in our care with the NHS and assigns you a designated GP.

**New Patient Registration Form**

This is to tell us a little bit about you and any specific needs you may have at our practice.

**Pharmacy Nomination**

Prescriptions sent electronically to your nominated pharmacy.

**Online Access**

Patient services registration. Once registered, an email will be sent to you to access.

Patient Access website: [www.patientaccess.com](http://www.patientaccess.com)

**Fast Test**

Part of government guidelines we are required to record alcohol screening data.

**Summary Care Record**

Summary Care Record is a record that is made available if you need emergency treatment to access your medical history/medication.

**IDENTIFICATION DOCUMENTS REQUIRED WHEN REGISTERING A NEW PATIENT – OVER 16 YEARS ONLY**

When returning the completed registration form, please bring your proof of identification. We are unable to register without this.

**PROOF OF NAME**

**(One of the following)**

Birth Certificate

Marriage Certificate

Driving Licence (Valid)

Passport (Valid)

**PROOF OF ADDRESS: MUST BE DATED WITHIN THE LAST 2 MONTHS**

**(One of the following)**

Utility Bill

Bank Statement

Council Tax Bill

Credit Card Statement

Letter from Benefits Agency

**\*PLEASE NOTE IF YOU ARE APPLYING FOR ONLINE ACCESS TO YOUR MEDICAL RECORDS, PHOTO ID MUST BE PROVIDED.**

**New Patient Registration**

**Additional Contact Information**

Home Telephone Number …………………………………………………………………………………..

Mobile or Work Telephone Number ……………………………………………………………………

Email Address …………………………………………………………………………………………………….

Next of Kin …………………………………………………………………………………………………………

Next of Kin Telephone Number ………………………………………………………………………….

**Do you look after a relative or friend, young or old, who is unable to care for themselves due to a physical or mental impairment or by age?**  **YES/NO**

If so, we would ask that you please complete the following:

Name and relationship of the person you are caring for ………………………………………………………….

…………………………………………………………………………………………………………………………………………………

**In order that we may take into account a patient’s culture, religion and background when providing appropriate individual care, your assistance in completing the next two sections is greatly appreciated as it helps us to improve our policies and practices.**

White British ………….. . Pakistani ……………

White Irish ............... Bangladeshi ……………

White Other ............... Other Asian background ……………

White & Black Caribbean ............... Black Caribbean ……………

White & Black Asian ............... Black African ……………

White & Asian ............... Other Black background ……………

Indian …………… Any Other ……………

Church of England ……………….. Buddhist ………………..

Catholic ……………….. Hindu ………………..

Other Christian ……………….. Muslim ………………..

Sikh ……………….. No Religion ………………..

Jewish ……………….. Other Religion ………………..

Jehovah’s Witness ……………….. (please state)

**Assistance During Appointments**

In order for us to provide you with any assistance you may require during consultations, please let us know if you would benefit from any of the following:-

First language **NOT** English – require a translator …………………..........

Deafness – require a sign language translator …………………………..

Disability – require a carer …………………………..

Chaperone – require a chaperone …………………………..

**Additional Information**

Height ………………….. Weight ………………

Have you ever served in the Armed Forces? **YES / NO**

**Smoking Status – Over 16 yrs**

Current Smoker ……………

Current Non-Smoker …………… --> Date/ Year Stopped Smoking …………………

Never Smoked Tobacco ……………

**Summary Care Record** (Please refer to additional information sheet)

**…………… Yes I would like a Summary Care Record –** you do not need to do anything and a Summary Care Record will be created for you.

…………… **Undecided** – enclosed is an opt out form. Please keep the form and hand it to a member of staff if you do decide to opt out and we can update your records accordingly.

…………… **No I do not want a Summary Care Record** – enclosed is an opt out form. Please complete the form and hand it to a member of the practice staff with your registration pack,

**Pharmacy Nomination**

We now issue prescriptions via the electronic Prescription Service (EPS)

It is your responsibility to register with the POD (Prescription Ordering Service) and to provide us with the pharmacy you would like to use in order for your prescription to be sent swiftly and to the right pharmacy.

**Nominated Pharmacy ……………………………………………………………………………………………………………**

**POD Telephone Number**

02476 246025 opening Times: Monday – Friday 8am – 5pm

EMIS WEB

**PATIENT SERVICES REGISTRATION FORM FOR NEW SYSTEM**

If you would like to register for this online service, please complete the form below and return it to Springhill Medical Centre, along with a valid form of photo identification, for example driving licence or passport. For GDPR, we cannot keep copies of your identification and this documentation will be securely shredded.

Once registered, Springhill Medical Centre will send you the information that will enable you to create a NEW username and password. This is because Springhill Medical Centre has migrated over to a new clinical system in October 2019.

\*\* PLEASE NOTE WE CANNOT ACCEPT REGISTRATION FORM WITHOUT PHOTO IDENTIFICATION\*\*

|  |  |
| --- | --- |
| Patient Details | Please complete in **BLOCK CAPITALS** |
| Patient Forename |  |
| Patient Surname |  |
| Date of Birth DD/MM/YYY |  |
| Email address | **\*\*You cannot use the same email address unless it is to link a child to your account\*\*** |
| Mobile Number |  |
| Signature |  |
| Date DD/MM/YYYY |  |
| **Completing the form on behalf of the patient** | |
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