

<b>Date of request</b>		<b>Occupation</b>	
<b>Surname</b>		<b>Address</b>	
<b>Forename</b>		<b>Postcode</b>	
<b>Title</b> ( <i>Mr/Mrs/Miss etc</i> )		<b>How long at this address?</b>	
<b>Date of Birth</b>		<b>Tel No:</b>	<i>Home</i>
			<i>Mobile</i>
<b>Proof of ID/Address seen</b> ( <i>state form of ID seen</i> )		<b>Email address:</b>	
		<b>Ethnic Origin</b>	<b>Main language</b>
<b>Name and Address of current or most recent GP</b>			
<b>Reason for wanting to join this practice</b>			
<b>Please give details of any current health problems</b>			
<b>Are you a carer?</b> Yes/No		<b>Do you have a carer?</b> Yes/No	
<b>Please list any medication you are taking on a regular basis</b>			
<i>(continue on reverse if necessary)</i>			
<b>Are you a resident in a nursing/residential care home</b>		<b>Yes</b>	<b>Yes/No</b>
<b>Do you have any family in Grimsby</b>			<b>Yes/No</b>
<b>If yes - are your family members registered with this practice</b>			<b>Yes/No</b>
<b>If yes - please give details ( Names, relationship etc)</b>			
<b>SHARED CARE</b>			
Other health services (e.g Local Hospital Services) may occasionally request shared access to your clinical records to enable them to make better informed decisions regarding any treatment you may need. If you do not wish to consent to this, please inform us in writing. If you do not inform us that you do not wish to share your records, we will assume that you consent to this.			
<b>Have you ever received treatment within a substance misuse treatment programme?</b>			
<i>(please circle)</i> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>			
If Yes, please list overleaf any medications or treatment you are currently or have recently been prescribed as part of a substance misuse programme either with your current/most recent GP or other treatment provider such as The Drug Intervention Programme, Addaction, The Junction, HMP or other provider. <i>(This will not affect your application to join this practice, but helps us to refer you to the most appropriate service for your needs)</i>			
<i>office use only</i>	GMS1 and new patient database forms issued		Initials
Accepted Y/N <i>If refused please state reason</i>			
Accepting GP	Date completed forms received		Initials
Patient informed (date)	New patient medical appointment made (date/time)		Initials
Health Visitor informed(if under 5)			

please complete one form for  
each person

please allow 21 days before ringing 582700 for outcome of application

<b>Medication list of patients currently or recently receiving treatment for substance misuse</b>

Please be aware this practice does not prescribe addictive medication.  
 We have an active policy of removing patients from our list if they fail to attend appointments  
 By requesting to join our practice you will be asked to sign a declaration to say you agree to abide by our rules and procedures some of which are:

In the case that you are accepted, it is mandatory that everyone over the age of 5 years has a new patient medical here at the surgery. If you do not attend for this, you will be removed.  
 We want to give you the best care that we can, this often means you attending for frequent check-ups - i.e. Asthma checks, over 75 year checks, cholesterol and weight reduction clinics, medication reviews and immunisations when requested.

**If you do not attend for the checks when requested, you will be removed.**

If you disagree with the above, then we are probably not the best practice for you and we respectfully suggest that you try elsewhere.

If you are happy with the above, please sign, print and date below and this will now be part of your medical record held with us.

<i>Signature</i>	<i>Please print name</i>	<i>Date</i>
------------------	--------------------------	-------------

**FINALLY: PLEASE NOTE WE ARE A ZERO TOLERANCE ZONE  
 WE WILL NOT ACCEPT ANY AGGRESSIVE OR INSULTING  
 BEHAVIOUR TO ANY STAFF MEMBER OR OTHER PATIENT**