WELCOME TO HEALTH PLUS

Registration Update/Amendment Form

PRIMARY

Please complete clearly all relevant sections of this registration update form.

1. Patient Information				
Title:	**Miss / Mr / Mrs / Ms / Mstr / Mx /**	Gender Identity: (please circle)	Female Male Trans Other	
Family Name:				
Given Name(s):		Ethnicity: Select A and B (please circle)	A: White Black Asian Mixed Other B: British European Other	
Known As:				
Previous Family Name:		Resident Since: Month/Year	/	
Date of Birth:		Usual GP:		
Jersey SSD No/Card:	Seen By:	Reason for Amendment:	☐ Change of Contact Details ☐ Change of Name (For change of name legal documents must be provided)	
Jersey SSD HIF Status: (For Practice to complete)	☐ HIO ☐ HMA ☐ Private	ID/Document Confirmed: (Passport / Driving Licence)	☐ Yes ☐ No	ID/Doc Type: Seen By:

2. Home Address and Contact Information (For ID purposes Utility Bill/Bank Statement or Tax/SSD Notification dated within 3 months is valid)				
Current Home Address		Home Telephone:		
		Work Telephone:		
		Mobile Telephone:		
		Personal Email Address:		
		Newsletter/Update Email Opt-in: (please circle)	Yes No	
Post-Code:		Address Confirmed: Dated within 3 months of issue	☐ Yes ☐ No	Doc. Type: Seen By:
Home Access Information: for impaired patient visits				

3. Emergency Contact/Next of Kin/Parent/Guardian Information			
Title:	**Miss / Mr / Mrs / Ms / Mx /**	Home Address & Post-Code: ☐ Same as Section 2	
Family Name:			
Given Name(s):			
Date of Birth:		Home Telephone:	
Relationship to Patient:		Work Telephone:	
Is This Your Next of Kin?:	☐ Yes ☐ No	Mobile Telephone:	
Consent for us to discuss relevant aspects of your medical record with this person until further notice:	☐ Yes ☐ No	Is this your main carer?:	☐ Yes ☐ No

PTO

4. Children Under Age of 16 in Same Household Information (All individuals must complete their own form)		
Child:		Date of Birth:
Child:		Date of Birth:
Child:		Date of Birth:

5. Private Medical Insurance Provider (The Patient is responsible for making all claims with their insurer)		
Insurance Provider:	Policy/Scheme Number:	Authorisation/Claim Number:

6. AUDIT-C Questionnaire

What is your average intake of alcohol per week in units?: Units
(Pint of Regular Beer/Lager/Cider = 1 Unit / Standard Glass of Wine = 2 Units / Bottle of Wine = 10 Units / Single Measure of Spirits = 1 Unit)

AUDIT-C Questionnaire

1. **How often do you have a drink containing alcohol?**
   ☐ a. Never ☐ b. Monthly or less
   ☐ c. 2-4 times a month ☐ d. 2-3 times a week ☐ e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   ☐ a. 1 or 2 ☐ b. 3 or 4
   ☐ c. 5 or 6 ☐ d. 7 to 9 ☐ e. 10 or more
3.
4. **How often do you have six or more drinks on one occasion?**
   ☐ a. Never ☐ b. Less than monthly
   ☐ c. Monthly ☐ d. Weekly ☐ e. Daily or almost daily

7. Patient Declaration, Confidentiality Agreement and Personal Data Statement

In the case of a child under the age of 16, this declaration should be signed 'for and on behalf of' the child named on this registration form by the Parent/Legal Guardian as given in section 3.

Your Personal Information (Data Protection and Patient Privacy):
The information collected on this application form will be used by Health Plus Limited (hereafter the 'Practice') for the purposes of healthcare related services and Practice administration. Personal information we hold about you is processed for the purposes of 'Employment and Social Fields' (Article 8) 'Medical Purposes' (Article 15) and 'Public Health' (Article 16) of the Data Protection (Jersey) Law 2018. This may require your personal data (including, relevant details of your medical history) to be shared with other approved healthcare providers for the purpose of referrals and for other lawful purposes related to the Practice procedures. Further information on how we hold and process your data can be found in our Data Protection and Patient Privacy Policy.

Children Aged 13-16
The Data Protection (Jersey) Law 2018 provides that a child aged between 13 and 16 has their own right to consent and data confidentiality privacy. Therefore if a child aged between 13 and 16 has "sufficient understanding and intelligence to enable them to understand fully what is proposed" (known as Gillick Competence), then they may be competent to give consent for themselves. Further information can be found in our Data Protection and Patient Privacy Policy.

General Practice Central Services (GPCS):
All Jersey GP Practices and other approved healthcare service providers, such as the out-of-hours doctors, use a central medical records system known as EMIS. This allows access to a 'shared medical record' to ensure that the provider or clinician has immediate up-to-date and accurate information about your health and any current treatment you may be having. You do however have the right to 'opt out' of sharing some or all of your medical records. Please ask us for more information and where appropriate an Opt-in/Out Form for completion. All approved healthcare service providers with authorised access to EMIS have signed strict confidentiality agreements which are bound by the Data Protection (Jersey) Law 2018.

Your Declaration to us:

- I confirm that all the information I have given in this registration form is accurate to the best of my knowledge.
- I understand that the Practice has the right to accept or decline my registration application at any time.
- I understand that by attending a consultation with a GP or other healthcare professional of the Practice, I accept the Practice terms of service and fee schedule issued and displayed in the Practice premises and as amended from time to time.
- I hereby agree to pay any incurred service fees from the Practice at the time of attendance or treatment.
- I expressly consent that on registration or prior to accepting any credit arrangement from the Practice, where appropriate a credit reference check may be taken with an authorised credit reference agency and/or my previous medical practice(s).
- I give my express permission for the Practice to request information including my medical records from my previously registered GP and I agree to reimburse the Practice for any charges and disbursements incurred relating thereto for the Practice being provided with such information.
- I understand it is my sole responsibility to advise the Practice in writing of any changes made in respect of my personal information.

Signed:	Print Name:	Dated:
Child Name:	Date of Birth:	

For Practice Use Only	Received by:	On EMIS By:	EMIS Number:
Medibooks:	Synchronised:	Billing Pattern:	Alternative Billing Address (Child)