ISLAND MEDICAL CENTRE

Patient Registration Form: ADULT

Individual patient registration forms must be completed for each adult and young person over the age of 16.
Please complete clearly all relevant sections of this registration form.

PRIMARY

1. Patient Information ☐					
Title:	**Miss / Mr / Mrs / Ms / Mstr / Mx /**	Gender Identity:	☐ Female ☐ Male ☐ Trans ☐ Other		
Family Name:		Marital Status:	☐ Single ☐ Married ☐ Civil Partnership ☐ Separated ☐ Divorced ☐ Other		
Given Name(s):		Ethnicity: Select A and B	A: ☐ White ☐ Black ☐ Asian ☐ Mixed ☐ Other B: ☐ British ☐ European ☐ Other		
Known As:		First Language: If not English			
Previous Family Name:		Resident Since: Month/Year	/		
Date of Birth:		Reason For Registering with the Practice:	☐ Transferring from another Jersey GP Practice ☐ Re-Registering with GP Practice ☐ New Resident In Jersey		
Jersey SSD No/Card:	Seen By:				
Jersey SSD HIF Status: (For Practice to complete)	☐ HIO ☐ HMA ☐ Private	Identification Confirmed: (Passport / Driving Licence)	☐ Yes ☐ No	ID 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 (1):		Home Telephone:			
		Work Telephone:			
		Mobile Telephone:			
		Personal Email Address:			
Post-Code:		Address Confirmed: Dated within 3 months of issue	☐ Yes ☐ No	Doc. Type:	Seen By:
Access Information: for impaired patient visits					

3. Previous Home Address (If less than three years at the current home address) ☐			
Previous Home Address (2):		Previous Home Address (3):	
Date From / To:	/	Date From / To:	/

4. Emergency Contact/Next of Kin 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:	
Your Next of Kin:	☐ Yes ☐ No	Mobile Telephone:	
Consent for us to Discuss Your Record:	☐ Yes ☐ No	Your Official Carer:	☐ Yes ☐ No