QUEENS ROAD MEDICAL PRACTICE

Accredited by CHKS Insight for better healthcare

FOR OFFICE USE ONLY
To be completed when forms returned & checked

Staff Initials: _____
Date: _____

New Patient Registration Form

This form is also available in large print. Please advise us if you require any assistance completing this form.
Please fill in this form in BLOCK CAPITALS

PERSONAL DETAILS			
Title			
Preferred Pronouns			
Forename(s)			
Preferred Name (if not Forename)			
Surname			
Date of Birth			
Sex at Birth		**Gender Identity**	
Ethnicity			
Home Address			
Postcode			

SOCIAL SECURITY		
GY Number	**GY**	
GY numbers allow you eligibility for the Health Benefit Grant. For more information, please visit www.gov.gg/socialsecurity If you do not have a GY number, you will have to access Pathology, Radiology, Pharmacy and Secondary Care Referrals privately. If you have not provided a GY number – please complete the below field:		
Applied for GY number?	**Yes** ☐	**No (Private)** ☐

PERSONAL OR PRIMARY CONTACT DETAILS		
Home Number		
Mobile Number		
Personal Email		
(Please note we are unable to accept work/joint email addresses)		
If the applicant is over 18 and the contact details above are not their own a **Friends & Family Disclosure of Information Consent Form** is required.	Name of contact:	
	Relationship to patient:	
Notifications relating to your care may be sent to you via email or SMS. This will be in the form of a secure link that requires you to confirm your identity before any sensitive information is disclosed. If you would like to opt out of electronic communication; tick here ☐		

QUEENS ROAD MEDICAL PRACTICE

Accredited by CHKS Insight for better healthcare

NEXT OF KIN DETAILS	
Next of Kin 1 Required for patients under 18 years old	Full Name: Relationship to Patient: Mobile:
Next of Kin 2	Full Name: Relationship to Patient: Mobile:

PREFERRED GP	
Which Doctor would you like to be registered with?	

INSURANCE DETAILS	
Insurance Company	
Policy Details	Policy Number: Customer Number: Start Date:

Insurance Coverage Disclosure:

By proceeding with treatment, the patient confirms that they have independently verified their insurance coverage for the services requested. It is the patient's sole responsibility to confirm with their insurance provider whether the proposed treatment(s) are covered, including any applicable co-pays, deductibles, or limitations.

Queens Road Medical Practice LLP operates under the assumption that this confirmation has been completed prior to scheduling or receiving care. We are not responsible for any denial of claims, partial reimbursements, or unexpected out-of-pocket expenses resulting from lack of insurance coverage. Any balance not covered by the patient's insurance remains the responsibility of the patient.

DETAILS OF PREVIOUS/CURRENT DOCTOR	
Name of Doctor	
Name of Surgery	
Practice Address	
Practice Telephone Number	

QUEENS ROAD MEDICAL PRACTICE

Accredited by CHKS Insight for better healthcare

DECLARATION

I understand that the Practice has the right to accept or decline this application.

I agree to pay for all treatment given by the Practice.
Full details of our pricing are available from reception or on our website at www.qrmp.gg

I give my permission to the Practice to request my previous medical history from my previous doctor.

I agree that the Practice may disclose personal details and details of medical records to all those involved in providing healthcare and related services both inside and outside the Practice.

To be signed by the applicant if aged 12 years or over.
To be signed by parent/guardian for applicants under the age of 12 years.

Signed		**Date**	
Print Name			

Please return this form with a copy of PHOTOGRAPHIC IDENTIFICATION to the Practice

WHAT HAPPENS NEXT?

If this is a first-time registration or you are transferring from outside of Guernsey

- We will process your application and contact you to book a free registration appointment with one of our nurses.
- We will attempt to request your past medical history from your previous GP if you have provided the details.

If you are currently registered at another local Practice

- We will process your application and request a transfer of your records from your previous Practice.
- Once your records have been transferred to us, we will contact you to book a free registration appointment with one of our nurses.
- If you require an appointment before we have informed you the transfer is complete, please book this with your current surgery.

You are not formally a patient of Queens Road Medical Practice until your application has been accepted and you have attended a free registration appointment.

If you have any questions, please contact the Health Management Department on 724184 or at admin@eqrmp.gg
For more information on Queens Road Medical Practice please visit our website at www.qrmp.gg

Your details will be stored and used as per our Privacy Notice; This can be viewed on our website and is also available upon request at reception.

FOR OFFICE USE ONLY
To be completed when clinical system updated

Staff Initials: _____
Date: _____