

## Interpractice Registration Form

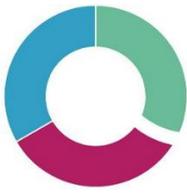
This form is also available in large print. Please advise us if you require any assistance completing this form.

**Please fill in this form in BLOCK CAPITALS**

<b>PERSONAL DETAILS</b>			
<b>Title</b>			
<b>Preferred Pronouns</b>			
<b>Forename(s)</b>			
<b>Preferred Name (if not Forename)</b>			
<b>Date of Birth</b>			
<b>Sex at Birth</b>		<b>Gender Identity</b>	
<b>Ethnicity</b>			
<b>Home Address</b>			
<b>Postcode</b>			

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

<b>PERSONAL OR PRIMARY CONTACT DETAILS</b>		
<b>Home Number</b>		
<b>Mobile Number</b>		
<b>Personal Email</b>		
If the applicant is over 18 and the contact details above are not their own a <b>Friends &amp; Family Disclosure of Information Consent Form</b> is required.	Name of contact:	
	Relationship to patient:	
<p>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.</p> <p>If you would like to opt out of electronic communication; tick here <input type="checkbox"/></p>		



**NEXT OF KIN DETAILS**

<b>Next of Kin</b> Required for patients under 18 years old	Full Name:
	Relationship to Patient:
	Mobile:

**INSURANCE DETAILS**

<b>Insurance Company</b>	
<b>Policy Details</b>	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 CURRENT GP PRACTICE**

<b>Name of Surgery</b>	
<b>Practice Address</b>	

**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](http://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.**

<b>Signed</b>		<b>Date</b>	
<b>Print Name</b>			

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

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.