IslandHealth
Committed to Patient Care Since 1894

Accredited by CHKS

SEASONAL WORKER REGISTRATION FORM

PLEASE COMPLETE THE FORM IN CAPITAL LETTERS
All sections MUST BE completed to enable your prompt registration to the Practice as a patient

SURNAME:	**FORENAMES:**	**TITLE:**
PREVIOUS NAME:	**DATE OF BIRTH:**	**PLACE OF BIRTH:**
SEX: MALE / FEMALE / OTHER	**LANGUAGE SPOKEN:**	
TEL NO – HOME:	**MOBILE:**	**WORK:**
GUERNSEY ADDRESS:		
		POST CODE:
EMAIL ADDRESS:	**RELIGION:**	**SOCIAL SECURITY GY NO:**

OCCUPATION:	**EMPLOYER:**	**TEL NO:**

INSURANCE COVER: BUPA / Foresters / AXA / WPA / Oddfellows / Allianz / None	**POLICY NO:**

NEXT OF KIN:		**RELATIONSHIP:**
TEL NO – HOME:	**MOBILE:**	**WORK:**

IF YOU HAVE MOVED TO GUERNSEY PLEASE STATE: YES / NO		**DATE OF ARRIVAL:**
INTENDED LENGTH OF STAY:	**PREVIOUS ADDRESS:**	
		POST CODE:
PREVIOUS DOCTOR:	**PREVIOUS DOCTORS ADDRESS:**	
	POST CODE:	**TEL NO:**

Have you any known allergies (e.g. medicines/stings/animals/etc)? YES / NO (please give details):	
Are you on any medication at the moment? YES / NO (please give details):	
Have you had any past serious illness or operations? YES / NO (please give details):	
Immunisations in the last 12 months? YES / NO (please give details):	
For female patients over 21 – Date of last Smear:	**Result:**

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 at the time of treatment. Failure to do so may result in recovery of outstanding debt being passed on to a third party for recovery of the debt on the Practice's behalf. No medical information would be passed over to the third party recovery agent.
I agree that the Practice may disclose personal details and details of medical records regarding both myself and my dependants to all those involved in providing me/them with healthcare and related services both inside and outside the Practice. I also agree to you requesting information from my previous doctor.
Please see IslandHealth's Privacy Notice in relation to any of your data we may hold, which can be found on our website or ask our Receptionist for a copy.

PATIENT NAME:	**SIGNATURE:**	**DATE:**

UPON COMPLETION, PLEASE RETURN THIS FORM WITH FORMAL PHOTO ID TO EITHER OF THE SURGERIES BELOW
L'Aumone Medical Centre – 256517 / St Sampson's Medical Centre – 245915 / Town Surgery – 724747

FOR OFFICE USE ONLY	**Received by & date:**	**Proof of ID copied: YES / NO**	**9344:**
Med Rec:	**Registered on Computer:**	**Registration Book:**	**Patient No:**
GY No: YES / NO	**Insurance Details: YES / NO**	**Copy to A/C's:**	