

Welcome to our Practice

Thank you for registering with us. Our aim is to provide services and facilities that will contribute towards a healthy future for you. As part of the registration process we ask you complete the enclosed pack – this will give us all of the information we need to ensure we have everything we need to provide you with the care you want and need.

Once you have completed all of the enclosed documents, please return this to the Practice along with two forms of identification (at least one of which must have a photo **and** current address – like a driving license – and the other must be either Photo ID or Address verification – a passport or recent utility bill).

Please complete all sections in **BLOCK CAPITALS**.

(Please be aware that this document is “double-sided”)

1.	Personal Details			
First Name		Sex	Male	Female
Middle Name(s)		Date of Birth		
Surname		Place of Birth		
Address				Postcode

Marital Status (delete as appropriate)	Single	Married	Cohabiting
	Common Law Partnership	Divorced	Widow / Widower

Next of Kin	First Name		Surname	
	Relationship to you			
	Telephone Number			

2.	Communication Preferences
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Important Information Please read the Guidance Note “SMS / Email consent” (page 2) before completing the SMS / Email Consent.

Only enter your contact information below (if you are entering the details of a carer or another individual then you must have their consent to do so).

Communication Type	Telephone Number	Primary Contact (tick only one)	Consent for SMS / Email
Mobile Telephone		<input type="checkbox"/>	<input type="checkbox"/>
Landline Telephone		<input type="checkbox"/>	<input type="checkbox"/>
Work Telephone		<input type="checkbox"/>	<input type="checkbox"/>
Alternate Telephone		<input type="checkbox"/>	<input type="checkbox"/>
Email Address			<input type="checkbox"/>

Guidance Note – SMS / Email Consent

The Three Chequers Medical Practice offers the complimentary service of providing SMS and email messages to all of our patients.

These messages might be relating to test results, appointment reminders or information about upcoming health campaigns and other information relating to your health or our services.



Although all text messages and emails are generated using a secure facility, they are transferred over a public network onto a personal telephone and, as a result of this, may not be secure. Messages sent via SMS or email will not contain “identifiable” information to ensure the preservation of your identity under the Data Protection Act 2018 (incorporating GDPR). As such, patients are encouraged **not to provide** consent for their number to be used for more than one record as this may lead to confusion regarding the identity of the intended recipient.

The Three Chequers Medical Practice **will never** share your personal information, including contact details, with a third party that is not involved with providing care to you.

It is important to note that patients who consent for SMS / email messaging can withdraw this consent at any time by informing a member of staff of their wish to do so.

Contact information given by a patient for their own records will **only** be used for information regarding them. The practice will never use these details to provide information about another family member.

These services are provided as a courtesy to our patients and as such, **no guarantee can be made that reminders and messages about test results will be sent on all occasions**; it remains the **responsibility of the patient** to attend, cancel or amend any appointment they have and to obtain the results of their tests.

Declaration			
I have read and understood the guidance note “SMS & Email Messaging”			<input type="checkbox"/>
The above contact information is mine or I have consent from the individual whose details I have given			<input type="checkbox"/>
I accept that SMS / Email messaging is an additional service and <i>may not</i> be sent on all occasions			<input type="checkbox"/>
I acknowledge that responsibility for attending / cancelling my appointments rests solely with me			<input type="checkbox"/>
I understand that SMS and Email services are sent via a secure system but that they are transmitted and received over a public network onto personal systems and, as such, may not be secure.			<input type="checkbox"/>
I accept that no “identifiable” information will be transmitted via SMS or Email to safeguard my identity against an information security breach			<input type="checkbox"/>
I take responsibility to ensure that my contact information is kept up-to-date with the Practice			<input type="checkbox"/>
I give my permission for Telephone Answerphone Messages to be left on my Landline / Mobile Telephone			<input type="checkbox"/>
Full Name			
Signature		Date	
Please tick here if you have signed on behalf of the patient			<input type="checkbox"/>

3.	Background Information
Previous GP Name	
Previous GP Address	
Country of Birth	

Ethnic Origin	White (British) <input type="checkbox"/>	Chinese <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Prefer not to say <input type="checkbox"/>
	White (Other) <input type="checkbox"/>	Indian <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Other (Specify) <input type="checkbox"/>
	Black (African) <input type="checkbox"/>	Black (Caribbean) <input type="checkbox"/>	Arabic <input type="checkbox"/>	

Religion	C of E <input type="checkbox"/>	Buddhist <input type="checkbox"/>	Sikh <input type="checkbox"/>	Atheist <input type="checkbox"/>
	Catholic <input type="checkbox"/>	Muslim <input type="checkbox"/>	Jewish <input type="checkbox"/>	Other (Specify) <input type="checkbox"/>
	Other Christian <input type="checkbox"/>	Hindu <input type="checkbox"/>	Jehovah's Witness <input type="checkbox"/>	

Living Accommodation	House <input type="checkbox"/>	Bungalow <input type="checkbox"/>
	Mobile Home <input type="checkbox"/>	Bedsit <input type="checkbox"/>
	Lodging <input type="checkbox"/>	Temporary <input type="checkbox"/>
	Ground Floor Flat <input type="checkbox"/>	Upper Floor Flat <input type="checkbox"/>
	Warden attended accommodation <input type="checkbox"/>	Residential Home <input type="checkbox"/>
	Homeless <input type="checkbox"/>	Nursing Home <input type="checkbox"/>

Employment	Employed <input type="checkbox"/>	Self-Employed <input type="checkbox"/>	Student <input type="checkbox"/>
	Unemployed <input type="checkbox"/>	Carer <input type="checkbox"/>	Retired <input type="checkbox"/>
	Housewife <input type="checkbox"/>	Househusband <input type="checkbox"/>	Other <input type="checkbox"/>

Are you a Military Veteran?	Yes <input type="checkbox"/>	Family Member <input type="checkbox"/>	No <input type="checkbox"/>
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4.	Language and Communication				
Language	First Language				
	Second Language(s)				
	Do you have any communication needs?			Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Hearing Loop <input type="checkbox"/>	Braille <input type="checkbox"/>	Translation services <input type="checkbox"/>		
	Large Print <input type="checkbox"/>	British Sign Language <input type="checkbox"/>	From English – To (specify)		
	“Easy-Read” <input type="checkbox"/>	Makaton Sign Language <input type="checkbox"/>			

Communicating with you

We want to communicate with you effectively, regardless of any difficulties you have in understanding how our letters, leaflets and other material is provided.

When write to you or contact you, do you need us to communicate in a particular way? Yes No

If your answer is “Yes”, please tell us how using the boxes below. You may tick more than one box, but please make your preference clear.



By Telephone

I prefer to use the telephone and I use a Hearing Aid.

I prefer to use the telephone and I don't use a Hearing Aid.



By Email

I do not use a Screen Reader

I use a Screen Reader



By Test Message (SMS)

I use a Text-to-speak app

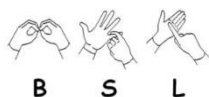
I do not use Text-to-speak app



With Easy Read pictures and words

A B

By using **Large Type**



I need a British Sign Language Interpreter

If you need anything that is not on the list, please tell our receptionist when you come in and we will do our best to meet your needs.

5. Medical History		
Have you ever suffered from any of the following conditions?		
Asthma <input type="checkbox"/>	Cancer (information below) <input type="checkbox"/>	COPD <input type="checkbox"/>
Depression <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Epilepsy <input type="checkbox"/>
Heart Disease <input type="checkbox"/>	Heart Failure <input type="checkbox"/>	High-Blood Pressure <input type="checkbox"/>
Kidney Disease <input type="checkbox"/>	Stroke <input type="checkbox"/>	Underactive Thyroid <input type="checkbox"/>
Any other condition, operations or hospital admissions or further information should be recorded below:		

Family History – please record any significant family history of close relatives with medical problems and confirm which relative it refers to (brother, mother etc)		
Asthma <input type="checkbox"/>	Cancer (information below) <input type="checkbox"/>	COPD <input type="checkbox"/>
Depression <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Epilepsy <input type="checkbox"/>
Heart Disease <input type="checkbox"/>	Heart Failure <input type="checkbox"/>	High-Blood Pressure <input type="checkbox"/>
Kidney Disease <input type="checkbox"/>	Stroke <input type="checkbox"/>	Underactive Thyroid <input type="checkbox"/>
Use this space to record which relatives any medical problem relates to and to give further information		

Allergies – please record known allergies or sensitivities below

Current Medication – please provide a list of medication in the space below. If possible, please also attach a list of your most recent repeat prescription

If you suffer from a Long-term Medical Condition, then you will have to have an annual review of your Medical conditions to check that you are receiving the correct treatment. Tick here to confirm that you understand this <input type="checkbox"/>

6.	Your Lifestyle
Alcohol – please answer the following questions which are validated as screening tools for alcohol use (use the Guidance Note – “Alcohol Unit Guide” on the following page)	

Question	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or Less	2 - 4 times per month	2 to 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 9	10+	
How often have you had 6 or more units if you are female; 8 or more units if you are male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
A score of less than 5 indicates “low-risk” drinking – you do not need to complete the next section.				Total		
A scored of 5 or more requires that you complete the next section						

Question	Scoring System (circle answer)					Your Score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you, or somebody else been injured as a result of your drinking?	No		Yes – not in the 12 months		Yes – in the last 12 months	
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested that you cut down	No		Yes – not in the 12 months		Yes – in the last 12 months	
					Total	

Guidance Note – Alcohol Unit Guide

One Unit of Alcohol is:



Half a pint of
standard
Lager, Beer or
Cider



A small glass
(125ml) of wine



A single shot of spirit



A small glass of
Sherry



A single measure of
Aperitif

Each of these is more than one unit:



A pint of 3.5%
Lager, Beer or
Cider

2 units



A pint of 5% Lager,
Beer or Cider

3 units



330ml bottle of 4.5%
Alcopop or Lager

1.5 units



A medium glass
(175ml) of wine

2 units



A bottle of wine

9 units



500ml can of 4%
Lager, Beer or
Cider

2 units



500ml can of 8%
Lager, Beer or
Cider

4 units



125ml glass of
Prosecco /
Champagne

1.5 units



Long-Island Iced
Tea Cocktail

4 units



Espresso Martini
Cocktail

2.5 units

6.	Your Lifestyle (continued)				
Smoking – Delete as appropriate					
Do you smoke?	Never		Ex-Smoker		Yes
How many cigarettes do you / did you smoke a day? (delete as required)	1 or less	2 – 9	10 -19	20 - 39	40+
Do you use an e-Cigarette or “Vape”	Never		Ex-user		Yes
Would you like help to quit smoking / “vaping”	Yes		No		For further information, please visit www.nhs.uk/smokefree

Height & Weight	
Height	Cm / Feet & Inches (delete as appropriate)
Weight	Stones & Pounds / KGs (delete as appropriate)

Women Only			
Do you use any contraception?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If needed, please book an appointment
Are you currently pregnant or think you may be?	Yes <input type="checkbox"/>	Expected due date	No <input type="checkbox"/>

7.	Further Details	
Patient Participation Group (PPG)		
We are committed to continually improving our services; the PPG is a mechanism for us to gain valuable feedback from our patients about their experiences, views and ideas for improving our services.		
Would you like to be involved in our PPG?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Organ Donation Register
From Spring 2020, Legislation is changing so that everyone in England is automatically registered as an Organ Donor.
If you would not like to be an Organ Donor, please tick here <input type="checkbox"/>

8.	Sharing Consent		
<p>The Practice takes its responsibility under the Data Protection Act 2018 very seriously and wants you to make informed decisions about how your details are shared.</p> <p>Please take a few moments to read the guidance “Sharing your Health Record” before continuing to provide consent.</p> <p>After you have read the guidance note and understood the information, you will be asked to provide consent for sharing your information</p>			
I have read and understood the Guidance entitled “Sharing your Health Record” (next page) <input type="checkbox"/>			
Do you consent to your GP Practice sharing your Health Record with other organisations who care for you?			
Yes (this is the recommended option)			<input type="checkbox"/>
No, never (not recommended, please discuss this with a GP before deciding)			<input type="checkbox"/>
Do you consent to your GP practice viewing your Health Record from other organisations that care for you?			
Yes (this is the recommended option)			<input type="checkbox"/>
No (not recommended, please discuss this with a GP before deciding)			<input type="checkbox"/>
Do you consent to having an Enhanced Summary Care Record with additional information?			
Yes (this is the recommended option)			<input type="checkbox"/>
No (not recommended, please discuss this with a GP before deciding)			<input type="checkbox"/>
Full Name			
Signature		Date	

Guidance Note – Sharing your Health Record

The Three Chequers Medical Practice takes its responsibility under the Data Protection Act 2018 (incorporating GDPR) very seriously.



Please read this information very carefully to understand why, how and when the Practice might wish to share your information with selected other organisations and why we ask for your consent to other organisations sharing your health record with us.

What is your health record?

Your health record contains all of the information about the care you receive. When you need medical assistance, it is essential to that the Clinician(s) involved in your care can securely access your health record, in order to provide treatment that is tailored to you, based on your medical background. This may include your medical history, medication and allergies.

Why is sharing important?

By sharing your health record, you receive the best possible care and treatment – wherever and whenever you need it. Choosing not to share your health record could have implications on the quality of care and treatment you receive in the future.

Some examples of how you can benefit from the sharing of your record are:

- **Sharing your contact details** ensures you received medical appointments without delay
- **Sharing your medical history** ensures emergency services accurately assess you if needed
- **Sharing your medication** list will ensure that you receive the most appropriate medication
- **Sharing your allergies** prevents you from being given something to which you are allergic
- **Sharing your test results** will prevent you from having to repeat tests more than required

Furthermore, it is important that we can see information that other organisations have added to your health record to ensure that you are receiving the best treatment possible.

Is my health record secure?

Yes. There are numerous safeguards in place to make sure that only organisation authorised to view your record can do so. You can request information regarding who has accessed your information at any time.

Can I decide who I share my health record with?

Yes, we will always ask for consent to share your health record unless it is an emergency – if you are unconscious for example.

Can I change my mind?

Yes – at any time, just let us know.

Can someone consent on my behalf?

If you do not have capacity to consent, then a Lasting Power of Attorney (LPA) may be able to consent on your behalf. If you do not have an LPA, then a “best interest” decision can be made on your behalf by those caring for you.

What about Parental Responsibility?

If you have parental responsibility and your child is not able to make an informed decision, then you can make a decision about information sharing on behalf of your child. If your child is deemed “competent” (to make an informed decision) then the decision is theirs.

What is a Summary Care Record?

A Summary Care Record (SCR) contains basic information about you (contact details, NHS number, medications and allergies etc). GP Practices, Hospitals and emergency services can view this. If you do not want an SCR, then ask the Practice for an “opt-out” form. You can provide consent for an “enhanced” SCR which will include information such as care plans, which will help ensure that you receive the care you require in the future.

Further information can be found at www.nhs.uk/nhsengland/thenhs/records

9. Accessing Online Services



systemonline
BOOK REQUEST REGISTER



Important Information Please read before completing the form

Patients who wish to, can use the internet to book appointments with a GP, request repeat prescriptions for any medications taken regularly and look at their medical record online. This is in addition to contact through traditional means for all of these services.

It is a patient's responsibility to keep their login details secure. If you suspect that your record has been accessed by someone who does not have permission to do so, then you should change your password immediately. If you are unable to do this, we recommend that you contact the practice so that online access can be revoked until the issue is resolved.

Any information printed from a patient's record, by a patient or their representative, is the responsibility of the patient (or representative) to keep secure. If you are worried about securely storing copies, we recommend that you do not make copies.

In the process of carrying out their normal duties, Practice staff have to input data to your record; this could be attaching a document received or something similar – you may notice administrator or reception staff names alongside some medical information – this is normal and not a cause for concern.

The definition of "Full Medical Record" is all of the information that is held in a patient's record, including; letters documents and free text added by staff, usually the GP. The coded record is all the information that is in coded form, like diagnosis, signs and symptoms – but excludes letters, documents and text.

Before applying for online access to your record, there are some things to consider. Although the chances of these circumstances are low, you will be asked to confirm that you have understood the following:

Forgotten History

There may be something that you have forgotten about in your record that you might find upsetting

Abnormal results or bad news

If you have access to test results or letters, you may see something that you find upsetting to you. This may occur before you have had a chance to speak to a Doctor or while the surgery is closed and unavailable for contacting

Choosing to share your information with someone

This is your choice to make, and may be very helpful for you – however, it is your responsibility to ensure that your information remains secure.

Coercion

If you think that you may be pressured into revealing details of your record to someone against your will, it is best that you do not register for online access.

Misunderstood Information

Your medical record is designed to be interpreted by clinical professionals to ensure you receive the best possible care; therefore some of the information within your medical record may be highly technical, written by specialists and not easily understood. Please contact the Surgery for clarification and explanation of your records.

Information about someone else

If you spot something in the record that is not about your, or there are other errors, please log out of the system immediately and contact the practice as soon as possible.

More information can be found at: www.nhs.uk/nhsengland/aboutnhservices/doctors/pages/gp-online-services.aspx

Before your request for online access can be processed, we will need to see photographic proof of your identity. In order to ensure that we can complete this request in a timely manner, please ensure that you have brought two forms of Identification (Photo & Address)

I wish to have online access to: (tick all that apply)	
View and book appointments	<input type="checkbox"/>
View and request medication	<input type="checkbox"/>
Access my <i>Coded</i> Medical record (definition provided on previous page)	<input type="checkbox"/>
Access my <i>Full</i> Medical record (definition provided on previous page)	<input type="checkbox"/>
Access my Summary Care Record	<input type="checkbox"/>
Complete online questionnaires	<input type="checkbox"/>

I wish to access my medical record and understand and agree with the statements below: (tick)	
I have read and understood the "Important Information" on the previous page	<input type="checkbox"/>
I accept that I am responsible for all information I see or download	<input type="checkbox"/>
If I share my information with anyone else, I accept that it is done at my own risk	<input type="checkbox"/>
I will contact the practice immediately if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
I will log out and contact the practice immediately if I see information in my record that is not about me, or is inaccurate.	<input type="checkbox"/>

Full Name			
Signature		Date	

For Practice use only:

Identity verified by	Self-Vouching <input type="checkbox"/>	Vouching through Information - Check <input type="checkbox"/>	
	Photo ID <input type="checkbox"/>	Proof of Residence <input type="checkbox"/>	Professional Vouching <input type="checkbox"/>
Name of Verifier		Date	
Name of Authoriser		Date	
Photocopied this page	<input type="checkbox"/> (name)		
Sent for Scanning	<input type="checkbox"/> (name)		

10.	Supplementary Information
Please complete the following questionnaire. By providing this information, not only can we improve the care and service you receive from us, it can also improve the service you receive from other agencies including Hospitals and district nursing teams, should you need them.	

With whom do you live?		Do you use a wheelchair?			
I live with (please specify)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
		If yes, what type of wheelchair do you use?			
I live alone (friends / family nearby)	<input type="checkbox"/>	Self-propelled wheelchair	<input type="checkbox"/>	Wheelchair pushed by another	<input type="checkbox"/>
I live alone (no friends / family nearby)	<input type="checkbox"/>	Motorised Wheelchair			<input type="checkbox"/>

Relationship Information			
Immediate Family	Please list all living immediate family members (Spouse / cohabiting partner, children / dependants, parents etc) <i>*add extra sheets as required*</i>		
Full Name	Relationship	DOB	Patient of Practice?
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

If you are a Widow or Widower, do you wish to have more information on our widows and widowers community events?			
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
		Not Applicable	<input type="checkbox"/>

Are you able to walk independently?	
Yes (please specify below) <input type="checkbox"/>	No (please specify below) <input type="checkbox"/>
Walk without difficulty <input type="checkbox"/>	Walk independently with stick <input type="checkbox"/>
	Walk with assistance from 1 person <input type="checkbox"/>
Walk independently with frame <input type="checkbox"/>	Walk with assistance from 2 or more people <input type="checkbox"/>
	Unable to walk at all <input type="checkbox"/>
Walk independently with aids <input type="checkbox"/>	Confined to chair <input type="checkbox"/>
	Bed-ridden <input type="checkbox"/>

Falls and Mobility					
Have you fallen over in the past 12 months?	Yes	<input type="checkbox"/>	Frequency	No	<input type="checkbox"/>
Have you struggled to get out of a chair without using your arms	Yes	<input type="checkbox"/>	Frequency	No	<input type="checkbox"/>
Are you taking four or more medications per day?	Yes	<input type="checkbox"/>		No	<input type="checkbox"/>
Have you been diagnosed with a Stroke or Parkinson's disease?	Yes	<input type="checkbox"/>		No	<input type="checkbox"/>
Do you occasionally have problems with your balance?	Yes	<input type="checkbox"/>		No	<input type="checkbox"/>

Mental Health - In the past 2 weeks, how often have you been bothered by any of the following problems (delete as appropriate)				
Question	Not at all (1)	Several Occasions (2)	More than half of the time (3)	Nearly always (4)
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling or staying asleep, or oversleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite or over-eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself – or that you are a failure and have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things, such as reading or watching the television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving or speaking so slowly that other people have noticed. Or being fidgety and restless a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thought about hurting yourself deliberately in any way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Registration Checklist

Please ensure you have completed and returned the following sections of the New Patient Registration Pack

Section Number & Title	Patient use Tick to confirm completion	Practice use Tick to confirm receipt and preferences
NHS Registration Form (GMS1) – <i>without this we cannot register you</i>		
1. Personal Details		
2. Communication Preferences		Coded <input type="checkbox"/>
3. Background Information		
4. Language and Communication		Dispensing Patient? <input type="checkbox"/>
5. Medical History		Enhanced SCR <input type="checkbox"/> Consent to share (out) <input type="checkbox"/> Consent for organisations to share with us (in) <input type="checkbox"/>
6. Your Lifestyle		Username and password given <input type="checkbox"/>
7. Further Details		
8. Sharing Consent		
9. Accessing Online Services		
10. Supplementary Information		
2 forms of identification provided:		
	Passport <input type="checkbox"/>	<input type="checkbox"/>
	Driving License (with current address) <input type="checkbox"/>	<input type="checkbox"/>
	Utility Bill (with current address) <input type="checkbox"/>	<input type="checkbox"/>
	Birth Certificate (or court order stating date of birth of child and parental responsibility) <input type="checkbox"/>	<input type="checkbox"/>