

New Patient Registration Form (Adult: 16 and over)

Instructions for completing this form

1. Complete a separate form for each family member to be registered
2. Complete in BLOCK CAPITALS and tick the boxes as appropriate

PLEASE ANSWER ALL THE QUESTIONS OR YOUR REGISTRATION MAY BE REJECTED OR DELAYED.

1	Full Name:				Date of Birth:	
	Title : <input type="checkbox"/> Mr		<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other. <i>Please state :</i>
	<i>Other. Please state :</i>				Marital Status:	
	Mobile tel. number:				Maiden name / Mothers name if different:	
	We will use this to send appointment reminders and health promotion details. Please tick here to give your consent for this: <input type="checkbox"/>				Current Address:	
	Home tel. number:				E-mail address:	
	Next of Kin: Relationship to Patient:				Next of Kin contact tel. number:	
	How would you prefer us to contact you: <input type="checkbox"/> Letter <input type="checkbox"/> Email <input type="checkbox"/> SMS (text) <input type="checkbox"/> Phone					
	Town* and Country of birth <small>(*If town is London please state which Borough)</small>		Country: Town:		Borough (*If born in London):	
Please list other residents of your home who are registered with us:		Name:		Date of Birth:		

2	Looking After A Family Member	
	Are you looking after someone? Let us know if you are looking after a friend or family member who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is someone looking after you? Let us know if a family member, friend or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice.	
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Carer's name :		Relationship to you:
Address of carer :		

Telephone number of carer :

3 Are You Currently Employed?			
If so please specify whether :	<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Self-employed
If you are not employed, please indicate which best describes you:			
<input type="checkbox"/> Retired	<input type="checkbox"/> Student	<input type="checkbox"/> Housewife/ Homemaker/Househusband	<input type="checkbox"/> Unemployed
<input type="checkbox"/> Other <i>Please state:</i>			
If returning from the Armed Forces please state which below:		Comments:	
<input type="checkbox"/> Army	<input type="checkbox"/> Royal Navy	<input type="checkbox"/> Royal Air force	

4 Your Religion (Please tick)	C of E <input type="checkbox"/>	Catholic <input type="checkbox"/>	Other Christian (state): <input type="checkbox"/>	Buddhist <input type="checkbox"/>	Hindu <input type="checkbox"/>	Muslim <input type="checkbox"/>
	Sikh <input type="checkbox"/>	Jewish <input type="checkbox"/>	Jehovah's Witness <input type="checkbox"/>	No religion <input type="checkbox"/>	Other religion (state) <input type="checkbox"/>	
Your Ethnic Origin (Please tick one)	White (British) <input type="checkbox"/>	White (Irish) <input type="checkbox"/>	White (Other) <input type="checkbox"/>			
Black Caribbean / British <input type="checkbox"/>	Indian / British Indian <input type="checkbox"/>	Arabic <input type="checkbox"/>	Other Mixed Background <input type="checkbox"/>			
Black African / British <input type="checkbox"/>	Pakistani / British Pakistani <input type="checkbox"/>	Chinese <input type="checkbox"/>	Other Asian Background <input type="checkbox"/>			
Other Black Background <input type="checkbox"/>	Bangladeshi / British Bangladeshi <input type="checkbox"/>	Other <input type="checkbox"/>	Ethnic Category Refused <input type="checkbox"/>			
What is your main spoken language?			Do you need an Interpreter?			
Do you speak English? Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>			
Do you need help with mobility/hearing/speaking? (tick all that apply)						
Wheelchair <input type="checkbox"/>	Walking aid <input type="checkbox"/>	Hearing aid <input type="checkbox"/>	British sign language (BSL) <input type="checkbox"/>	Makaton sign language <input type="checkbox"/>		
Lip reading: <input type="checkbox"/>	Large print: <input type="checkbox"/>	Braille <input type="checkbox"/>	Other. <i>Please state:</i> <input type="checkbox"/>			
Are you currently?	Homeless <input type="checkbox"/>	A Refugee <input type="checkbox"/>	An Asylum Seeker <input type="checkbox"/>			
Are you housebound?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Comments:			

Please state all countries you have lived in or visited for periods of greater than 6 months:	
Country:	Dates/Year (If known):

5	Lifestyle						
	Are you currently a smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been a smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No			If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a day?			
	If you are a smoker and want to STOP please tick here: <input type="checkbox"/>						
	Alcohol:		Scoring System				Your Score
			0	1	2	3	
	How often do you have a drink containing alcohol?		Never	Monthly Or Less	2-4 Times Per Month	2-3 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 female, or 8+ if male, on a single occasion in the last year?		Never	Less Than Monthly	Monthly	Weekly	Daily Or Almost Daily	
*Alcohol Units: 1 Pint Of Premium Beer = 2.5 Units. 1 Pint Beer/Cider = 2 Units. Single Measure Of Spirit = 1 Unit. Small (125ml) Glass Of Wine = 1 Unit						Total Score	

6	Diet and Exercise		What type of diet do you have?	
	How much exercise do you do?		<input type="checkbox"/> Healthy	
	<input type="checkbox"/> Sedentary (No exercise)		<input type="checkbox"/> Unhealthy	
	<input type="checkbox"/> Gentle (climbs stairs, walking , gardening)		<input type="checkbox"/> Vegan	
	<input type="checkbox"/> Moderate (Cycling, swimming regularly)		<input type="checkbox"/> Vegetarian	
	<input type="checkbox"/> Vigorous (Attends gym regularly)		<input type="checkbox"/> Moderate	
Please enter your height in		Please enter your weight in		
Feet / inches:	cm:	Kilos/grams:	Stones / lbs:	

7	Women Only		What is the date of your last Smear test ?	Date:	Result:
	Was this at your GP Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last Mammogram (if applicable):		
	Number of pregnancies (include miscarriages & terminations) (If applicable)				
	Do you wish to see a doctor in this Practice for contraceptive services (including the pill, coil or cap)?				

8 Your Medical Background				
Family History: Are there any serious diseases that affect your parents, brothers or sisters? Tick all that apply <u>and</u> state family member:				
<input type="checkbox"/> Diabetes Who:	<input type="checkbox"/> Asthma Who:	<input type="checkbox"/> Thyroid disorder Who:	<input type="checkbox"/> Stroke Who:	<input type="checkbox"/> COPD Who:
<input type="checkbox"/> Heart Attack under age of 60 Who:	<input type="checkbox"/> Cancer (Specify type) Who:	<input type="checkbox"/> High Blood pressure Who:	Any other important family illness. <i>Please state:</i> Who:	
Please state any allergies and sensitivities you have to medicines, food & dressings:				
Please state any mental disabilities you have:				
Are you able to administer your own medicines?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<i>If no</i> please give details, e.g. swallowing or opening containers:	
What long term medical conditions have you had?				Date of Diagnosis:
What operations or serious injuries have you had?				Date of operations or injuries:
Please list any tablets, medicines or other treatments you are currently taking / undertaking:				
We can now send your prescriptions electronically to the pharmacy of your choice. If you would like us to do this, please give the name and location of the pharmacy here:				

9 Sharing Your Medical Record	
<p>Medical Record Sharing allows your complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your shared medical record. If you don't want to share your GP record tick here: <input type="checkbox"/></p>	
<p>Summary Care Record contains details of your key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your Summary Care Record. If you don't want to have a Summary Care Record tick here: <input type="checkbox"/></p>	
<p>The Care.data Programme Collates information about you and the care you receive. It links information from all the different places where you receive care, such as your GP, hospital and community services, to help them provide a full picture of your medical needs and the care you are receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes. I wish to OPT OUT from my Personal Confidential Data being shared outside my GP practice: <input type="checkbox"/> I wish to OPT OUT from my Personal Confidential Data being shared with third parties: <input type="checkbox"/></p>	

10	Patient Participation Group (PPG)	
<p>The Practice is committed to improving the services we provide to our patients. To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.</p> <p>If you are interested in getting involved in the PPG, please tick yes in the box below and we will contact you with further details.</p>		
<u>Yes</u> I am interested in becoming involved in the PPG <input type="checkbox"/>		<u>No</u> I am not interested in becoming involved in the PPG <input type="checkbox"/>

11	Online Services : Book Appointments, Order Medication, View your Record, Update details and More	
NHS APP		
<p>We encourage all patients to download the NHS App to their smartphone by searching 'NHS APP' on the Google Play store or Apple store.</p> <p>The NHS App allows you to order your repeat medications, book appointments, update your contact details, view your medical record, contact your surgery, access a symptom checker, register your organ donation decision and more.</p> <p>If you would like help installing the NHS App, please ask a receptionist.</p> <p>For more information, visit www.nhs.uk/nhsapp</p>		
<u>Yes</u> - I will download the NHS APP <input type="checkbox"/>		<u>No</u> I don't want to register for online services <input type="checkbox"/>

12	Electronic Prescription Service	
<p>The electronic prescription service allows your GP to send your prescription directly to your pharmacy of choice without you needing to attend the surgery. The choice of pharmacy can be changed at any time.</p> <p>Would you like to nominate a pharmacy for your GP to send your prescriptions to?</p>		
<u>Yes</u> <input type="checkbox"/>		<u>No</u> I don't want to nominate a pharmacy <input type="checkbox"/>
Pharmacy Name: _____		
Pharmacy Address: _____		

13	Other Information	
	Do you have a " Living Will "? (A statement explaining what medical treatment you would not want in the future)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you nominated someone to speak on your behalf (<i>e.g. a person who has Power of Attorney</i>)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", please state their Name: Address: Phone number:
		If "Yes", can you please bring a written copy of it to your first appointment?

14	Signature	
	Patient signature:	Signature on behalf of patient:

Thank you for completing this form. *For more information about the services we offer, please refer to our practice leaflet or see our website*

For Office Use Only:

Date Received	
Received by	
Photo ID Seen (specify)	
Proof Address Seen	
Online Access	[Y] [N]
Nominated Pharmacy	[Y] [N]

Date Registered	
Registered by	