☐ Form logged + Initials?

New Patient Registration Form

Please complete all pages in full using block capitals

1. Background Details

Contact Details			
Name		Gender	
Address		Date of Birth	
		Home Telephone	
		Work Telephone	
Mobile Telephone	I consent to be contacted* by SMS on this number:		
Email	I consent to be contacted* by email at this address:		
Next of Kin	Name: Tel: Relationship:		

** It is your responsibility to keep us updated with any changes to your telephone number, email & postal address. We may contact you with appointment details, test results or health campaigns.*
*If you **do not consent** to being contacted by SMS or Email, please tick here:* ☐ *SMS* ☐ *Email*

Other Details	
Country of Birth	
Ethnicity	☐ White (UK) ☐ White (Irish) ☐ White (Other) ☐ Black Caribbean ☐ Black African ☐ Black Other ☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Chinese ☐ Other

Communication Needs	
Language	What is your main spoken language? Do you need an interpreter? ☐ Yes ☐ No
Communication	Do you have any communication needs? ☐ Yes ☐ No (If **Yes** please specify below) ☐ Hearing aid ☐ Large print ☐ British Sign Language ☐ Lip reading ☐ Braille ☐ Makaton Sign Language ☐ Guide dog

Carer Details		
Are you a carer? (Do you look after a friend or family member who due to illness, disability, a mental health problem or addiction cannot cope without your support?)	☐ Yes – Informal / Unpaid Carer ☐ Yes – Occupational / Paid Carer ☐ No	
Do you **have** a carer? (This could be a friend or family member, or someone from a care agency.)	☐ Yes	Name*: Tel: Relationship:

** Only add carer's details if they give their consent to have these details stored on your medical record*

Military Veteran, Military Personnel and Service Families		
Are you a veteran?	☐ Yes	☐ No
Are you actively serving full time or a reservist?	☐ Yes	☐ No
Are you a spouse/family member of someone actively serving full time or a reservist?	☐ Yes	☐ No

2. Medical History

Medical History

Have you suffered from any of the following conditions?

☐ Asthma	☐ Heart Disease	☐ Diabetes	☐ Depression
☐ COPD	☐ Heart Failure	☐ Kidney Disease	☐ Underactive Thyroid
☐ Epilepsy	☐ High Blood Pressure	☐ Stroke	☐ Cancer- Type:

Any other conditions, operations or hospital admission details:

If you are currently under the care of a Hospital or Consultant outside our area, please tell us here:

Family History

Please record any significant family history of close relatives with medical problems and confirm which relative e.g. mother, father, brother, sister, grandparent

☐ Asthma……..	☐ Heart Disease……..…	☐ Diabetes……..……	☐ Depression……..……
☐ COPD……...….	☐ Stroke…….……..	☐ Kidney Disease..……	☐ Thyroid……..……..
☐ Epilepsy……	☐ Blood Pressure……	☐ Liver Disease..…..……..	☐ Cancer……..

Other:

Allergies

Please record any allergies or sensitivities below

Current Medication

Please check and include as much information about your current medication below
Please give us your previous repeat medication list if possible and a medication review appointment may be needed

3. Your Lifestyle

Alcohol

Please answer the following questions which are validated as screening tools for alcohol use:

AUDIT–C QUESTIONS	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	2-3 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 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL:	

A score of **less than 5** indicates *lower risk drinking*

Scores of 5 or more requires the following 7 questions to be completed:

AUDIT QUESTIONS (after completing 3 AUDIT-C questions above)	Scoring System					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 from 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, but not in last year		Yes, during last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in last year		Yes, during last year	
					TOTAL:	

3. Your Lifestyle - Continued

Smoking	
Do you smoke?	☐ Never smoked ☐ Ex-smoker ☐ Yes
Do you use an e-Cigarette?	☐ No ☐ Ex-User ☐ Yes
How many cigarettes did/do you smoke a day?	☐ Less than one ☐ 1-9 ☐ 10-19 ☐ 20-39 ☐ 40+
Would you like help to quit smoking?	☐ Yes ☐ No For further information, please see: www.nhs.uk/smokefree

Height & Weight	
Height	
Weight	

Women Only	
Do you use any contraception? Are you currently pregnant or think you may be? Date of last smear? (If you have had one) Dates of any pregnancies	☐ Yes ☐ No If needed, please book appointment. ☐ Yes ☐ No Expected due date:

4. Further Details

Electronic Prescribing	
If you would like your prescriptions to be sent electronically, please provide details of the pharmacy you would like to use:	Pharmacy: Postcode:

Signatures	
Signature	I confirm that the information I have provided is true to the best of my knowledge. ☐ Signed on behalf of patient
Name	
Date	

5. Sharing Your Health Record

Your Health Record

Do you consent to your GP Practice sharing your health record with other organisations who care for you?

☐ Yes *(recommended option)*
☐ No, never

Do you consent to your GP Practice viewing your health record from other organisations that care for you?

☐ Yes *(recommended option)*
☐ No

Your Summary Care Record (SCR)

Do you consent to having an Enhanced Summary Care Record with Additional Information?

☐ Yes *(recommended option)*
☐ No

Signature

Signature	☐ Signed on behalf of patient
Name	
Date	

Sharing Your Health Record

What is your health record?

Your health record contains all the clinical information about the care you receive. When you need medical assistance it is essential that clinicians can securely access your health record. This allows them to have the necessary information about your medical background to help them identify the best way to help you. This information may include your medical history, medications and allergies.

Why is sharing important?

Health records about you can be held in various places, including your GP practice and any hospital where you have had treatment. Sharing your health record will ensure you receive the best possible care and treatment wherever you are and whenever you need it. Choosing not to share your health record could have an impact on the future care and treatment you receive. Below are some examples of how sharing your health record can benefit you:

- Sharing your contact details — This will ensure you receive any medical appointments without delay
- Sharing your medical history — This will ensure emergency services accurately assess you if needed
- Sharing your medication list — This will ensure that you receive the most appropriate medication
- Sharing your allergies — This will prevent you being given something to which you are allergic
- Sharing your test results — This will prevent further unnecessary tests being required

Is my health record secure?

Yes. There are safeguards in place to make sure only organisations you have authorised to view your records can do so. You can also request information regarding who has accessed your information from both within and outside of your surgery.

Can I decide who I share my health record with?

Yes. You decide who has access to your health record. For your health record to be shared between organisations that provide care to you, your consent must be gained.

Can I change my mind?

Yes. You can change your mind at any time about sharing your health record, please just let us know.

Can someone else consent on my behalf?

If you do not have capacity to consent and have a Lasting Power of Attorney, they may consent on your behalf. If you do not have a Lasting Power of Attorney, then a decision in best interests can be made 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 for themselves, then you can make a decision about information sharing on behalf of your child. If your child is competent then this must be their decision.

What is your Summary Care Record?

Your Summary Care Record contains basic information including your contact details, NHS number, medications and allergies. This can be viewed by GP practices, Hospitals and the Emergency Services. If you do not want a Summary Care Record, please ask your GP practice for the appropriate opt out form. With your consent, additional information can be added to create an Enhanced Summary Care Record. This could include your care plans which will help ensure that you receive the appropriate care in the future.

How is my personal information protected?

The surgery will always protect your personal information. For further information about this, please see our Privacy Notice on our website or please speak to a member of our team

For further information about your health records, please see: www.nhs.uk/NHSEngland/thenhs/records
For further information about how the NHS uses your data for research & planning and to opt-out, please see: www.nhs.uk/your-nhs-data-matters