**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

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| **1** | **Full Name:**  **Preferred name, if it is different to the above:** | | **Date Of Birth:** | |
| **Title:**  **Miss**  **Mr**  **Ms**  **Mrs**  **Mx.**  **Other** Please specify**………………………….** | | **What best describes your gender?:**  **Man**  **Woman**  **Transgender woman**  **Transgender man**  **Non-binary**  **A gender not listed here**  please provide further information: **…………………………………………………..**  **Prefer not to say**  You can provide further information here if you wish to:  **………………………………………………………**  **………………………………………………………** | |
| **NHS Number:** | |  | |
| **Mobile tel. number:**  **Alternative Number.**  We will use this to send appointment reminders. Please tick here to give your consent for this: | | **Current Address:** | |
| **Previous Address:**  **(**address where you last registered with a GP) | |
| **Next Of Kin Name:** | | **E-mail address:** | |
| **Relationship to Patient:** | | **Next of Kin contact tel. number:** | |
| **Please indicate your first choice of contact method:**  **Letter  Email  SMS (text)  Phone** | | | |
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| **Please list other relatives of your home who are registered with us:** | | | |
| **Relationship:** | **Name:** | | **Date of Birth:** |

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| **2** | **Looking After Someone** | | | |
| **Are you looking after someone?**  Let us know if you are looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems. | | Yes  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. | | Yes  No | |
| **Carer’s name :** | **Relationship to you:** | |  |
| **Address of carer** : | | |
| **Telephone number of carer** **:** | | |

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|  | What long term medical conditions have you had? | Date of Diagnosis: |
| Please list any tablets, medicines or other treatments you are currently taking / undertaking: **Please include the medication name and dose you are currently taking**  **1.**………………………………………………………………………………………............  …………………………………………………………………………………………………  **2.**………………………………………………………………………………………………  ………………………………………………………………………………………………….  **3.**………………………………………………………………………………………………  ………………………………………………………………………………………………….  **4.**………………………………………………………………………………………………  ………………………………………………………………………………………………….  **5.**………………………………………………………………………………………………  ………………………………………………………………………………………………..  **6.**………………………………………………………………………………………………  …………………………………………………………………………………………………  **7.**………………………………………………………………………………………………  …………………………………………………………………………………………………  **8.**………………………………………………………………………………………………  …………………………………………………………………………………………………  **9.**……………………………………………………………………………………………….  …………………………………………………………………………………………………  **10.**……………………………………………………………………………………………… |  |
| 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 address of the pharmacy here: | |

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| **3** | **Are You Currently Employed?** | | | | |
| **If so please specify whether :** | | **Full-time** | **Part-time** | **Self-employed** |
| **If you are not employed, please indicate which best describes you:** | | | | |
| **Retired** | **Student** | **Housewife/ Homemaker/House husband** | | **Unemployed** |
| **Other *Please state***: | | | | |
| **If returning from the Armed Forces, please state which below: Comments:**  **Army**  **Royal Navy**  **Royal Air force** | | | | |

**Religion**

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|  | **Your Ethnic Origin**  (Please tick one) | | White (UK) | | White (Irish) | | White (Other) |
| Black Caribbean/British | | Indian/British Indian | | Arabic | | Other Mixed Background |
| Black African / British | | Pakistani  British Pakistani | | Chinese | | Other Asian Background |
| Other Black Background | | Bangladeshi /  British Bangladeshi | | Other | | Ethnic Category Refused |
| **What is your main spoken language?**  **Do you speak English?** Yes No | | | | **Do you need an Interpreter?**  Yes  No | | |
| **Are you currently?** | Homeless | | A Refugee | | An Asylum Seeker | |
| **Are you housebound?** | Yes  No | | Comments: | | | |

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|  | **Please enter your height in** | | **Please enter your weight in** | |
| **Feet / inches:** | **cm:** | **Kilos/grams:** | **Stones / lbs:** |

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| **4** | **Lifestyle** | | |
| **Are you currently a smoker?**  Yes  No  **Have you ever been a smoker?**  Yes  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:** | | |
| **Alcohol** | Alcohol consumption is measured in units, which is explained in the diagram below. | |
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| Please have a look at the above diagram and then answer the questions on the next page. | | |

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| **Questions about your Alcohol Consumption** | **Scoring System** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| 1. 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 |  |
| 1. 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+ |  |
| 1. 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 |  |
| **If your total score for the above 3 questions is 4 or less, then you do not need to complete the questions below** | | | | | | |
| 1. 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 |  |
| 1. 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 |  |
| 1. 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 |  |
| 1. 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 |  |
| 1. 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 |  |
| 1. Have you or somebody else been injured as a result of your drinking? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |
| 1. 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 the last year |  | Yes, during the last year |  |

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**Total AUDIT Score (Questions 1 – 10):**

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence.

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| **5** | **Women Only**  **Please also complete this if you are a transgender man** | What is the date of your last ***Smear test***? | | Date: | Result: |
| Was this at your GP Surgery? | Yes  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)? | | | | Yes  No |

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|  | What long term medical conditions have you had? | Date of Diagnosis: |
| 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: | |

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| **6** | **Sharing Your Medical Record** |
| **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.  **Do you agree to the doctor sharing your medical record with other healthcare professionals using SystmOne ?**  **Yes  No** |
| **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. Ask your GP about the optional ‘Additional information’ choice.  **If you don’t want to have a Summary Care Record tick here:** |

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| **7** | **Patient Participation Group (PPG)** | |
| 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.  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. | |
| ***Yes***  I am interested in becoming involved in the PPG | ***No*** I am not interested in becoming involved in the PPG |

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| **8** | **Online Services** | |
| You can now do the following online or via the SystmOnline app:   * Book and cancel appointments, order repeat prescriptions, view your Detailed Medical Record.   IT WILL BE YOUR RESPONSIBILITY TO KEEP YOUR LOGIN DETAILS AND PASSWORD SAFE AND SECURE. IF YOU KNOW OR SUSPECT THAT YOUR RECORD HAS BEEN ACCESSED BY SOMEONE THAT YOU HAVE NOT AGREED SHOULD SEE IT, THEN YOU SHOULD CHANGE YOUR PASSWORD IMMEDIATELY. | |
| ***Yes***  I’d like to register for online services | ***No*** I don’t want to register for online services |

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| **9** | **Other Information** | | |
| Do you have a “***Living Will***” or “Advanced Directive”?  (A statement explaining what medical treatment you would not want in the future)? | Yes  No | ***If “Yes”,*** can you please bring a written copy of it to your first appointment? |
| Have you nominated someone to speak on your behalf (***e.g. a person who has Lasting Power of Attorney***)?  Yes  No | ***If “Yes”,*** ***please state*** their  Name:  Address:  Phone number: | |

* **Please book a New Patient appointment if you are on any regular medication**

**or have any chronic or significant medical condition**

* **Please request a copy of the Practice Leaflet if you have not already received it.**

**Alternatively you can also find more information on our practice website**

* **I confirm that I have completed this form as accurately and honestly as possible and**

**would like to apply to be registered as a patient at this practice**

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| **10** | **Signature** | **Date:** |
| Patient signature: | Signature if signing on behalf of patient: |