NEW PATIENT REGISTRATION FORM PLEASE NOTE *- YOUR NAMED DOCTOR WILL BE:*

TELL US ABOUT YOURSELF - PLEASE WRITE CLEARLY AND COMPLETE ALL RELEVANT BOXES

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  | | --- | --- | --- | --- | | Title: |  | Precise Town, County & Country of Birth: |  | | First Name(s): |  | Home Address: |  | | Surname: |  | Postcode: |  | | Previous Surname(s): |  | Telephone No. | 🞏Preferred contact | | Date of Birth: |  | Mobile Number: | 🞏Preferred contact | | Email address: |  | | | | Male or Female: |  | NHS Number (if known) |  |   PLEASE TELL US ABOUT YOUR NEXT OF KIN   |  |  |  |  | | --- | --- | --- | --- | | Name of your next of kin: |  | Their relationship  to you: |  | | How can we contact your next of kin if necessary? | Telephone: | Mobile: | Address: |   PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING INFORMATION: | |
| Your previous address in UK, including postcode |  |
| Name of Doctor while at this Address |  |
| Address of previous Doctor |  |
| IF YOU ARE FROM ABROAD |  |
| Your first UK address where registered with a GP, including postcode |  |
| Date you first came to live in UK: |  |
| Date you expect to be leaving UK (if known): |  |
| If previously resident in UK, date of leaving: |  |
| |  |  | | --- | --- | | Are you a military dependent? | YES / NO | | Are you a military veteran? | YES / NO | | Service or Personnel Number of yourself/spouse/parent etc |  |   IF YOU ARE RETURNING FROM THE ARMED FORCES: | |
| Address before enlisting, including postcode |  |
| Enlistment Date: |  |
| Discharge Date:  Do you wish to be known as a Veteran on our clinical system? | Yes / No (Please circle your answer) |
| FOR ALL TO COMPLETE – PLEASE READ THE ENCLOSED LETTER TITLED SUMMARY CARE RECORD – YOUR EMERGENCY CARE SUMMARY (PAGE 8) BEFORE COMPLETING THIS SECTION: | |
| I agree to Basic Summary Care Record  I agree to an ENRICHED Summary Care Record  I do not want a Summary Care Record  I agree to sharing my data on SystmOne for my direct care | 🞏  🞏 (see page 8 for more information on SCR)  🞏  Yes / No (select No to opt out) see page 8. |
| Signature of patient: | Date: |

|  |  |  |  |
| --- | --- | --- | --- |
| SUPPLEMENTARY QUESTIONS | | | |
| PATIENT DECLARATION for all patients who are not ordinarily resident in the UK | | | |
| Anybody in England can register with a GP practice and receive free medical care from that practice.  However, if you are not ‘ordinarily resident’ in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Are must also have the status of ‘indefinite leave to remain’ in the UK.  Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.  More information on ordinarily residence, exemptions and paying for NHS services can be found in the Visitors & Migrants patient leaflet, available from your GP practice.  You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.  The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.  Please tick one of the following boxes:   1. 🞏 I understand that I may need to pay for NHS treatment outside of the GP practice 2. 🞏 I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge (“the surcharge”), when accompanied by a valid visa. I can provide documents to support this when requested 3. 🞏 I do not know my chargeable status   I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.  A parent/guardian should complete the form on behalf of a child under 16. | | | |
| Signed: |  | Date: |  |
| Print name: |  | Relationship to  patient: |  |
| On behalf of: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK. | | | |
| NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS | | | |
| Do you have a non-UK EHIC or PRC? | YES: 🞏 NO: 🞏 | if yes, please enter details from your EHIC or PRC below: | |
| C:\Users\keeley.bruce2\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\F6EJQX6Z\Carte_Européenne_d'Assurance_Maladie_France[1].jpg  If you are from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC)/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital. | Country Code: |  |  |
| 3. Name |  |  |
| 4. Given Names |  |  |
| 5. Date of Birth | DD MM YYYY |  |
| 6. Personal Identification Number |  |  |
| 7. Identification number of the institution |  |  |
| 8. identification number on the card |  |  |
| 9. Expiry Date: | DD MM YYYY |  |
| PRC Validity period  (a) From | DD MM YYYY | (b) To: | DD MM YYYY |
| Please tick 🞏 if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). Please give your S1 form to the practice staff. | | | |
| How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.  Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country. | | | |

This portion of the form (page 3-7) gets detached during the registration process and dealt with separately, apologies if you are providing information already given in the previous pages.

HEALTH QUESTIONNAIRE

Please complete this questionnaire as fully as possible. The information will help the health care team to make an initial assessment of your health which will help in your future treatment. It can take several months to obtain your medical notes from your previous doctor and the more information we have, the better we can help you.

|  |  |
| --- | --- |
| PERSONAL DETAILS | |
| Surname: | First name(s): |
| Previous surname(s): | Sex: Male/female  Title: Mr/Mrs/Miss/Ms/Dr/Other |
| Date of birth: | Occupation: |
| Home address: | |
| Home tel: | Mobile tel: |
| Work tel: | Email: |

|  |
| --- |
| CHILDREN UNDER 18 |
| Name of school currently attending: |
| Name of responsible adult: (*responsible adult is the natural mother or parents if married at time of birth, or an individual given legal custody)* |

|  |  |
| --- | --- |
| WOMEN ONLY |  |
| Date of last cervical smear: |  |
| Result: |  |
| Have you had a hysterectomy? |  |

|  |  |
| --- | --- |
| HEALTH INFORMATION | |
| Height: | Weight: |
| Do you smoke? Yes / No  Cigarettes/cigars/pipe/roll-ups | If yes, how many per day? |
| Have you ever smoked? Yes/no | If you have stopped smoking, give approximate date you stopped: |
| *We strongly recommend that patients do not smoke. If you would like advice or help to give up smoking please speak to either your GP, nurse or enquire at reception for details of our smoking cessation services.* | |
| Do you have any allergies? animals/pollen/nuts/medication/other (please specify) | |
| Have you ever suffered from a bad reaction to any medication? Yes/no  If yes, please give details: | |
| What medication do you currently take? (include both prescription and over the counter, please attach a previous repeat medication slip if you have one): | |
| If you have any medication you need ‘on repeat’ please speak to a member of reception as you will need to book an appointment with a doctor before you run out of medication. | |
| What regular exercise do you take? | |

|  |
| --- |
| PERSONAL & FAMILY MEDICAL HISTORY |
| Have any close relatives (parents, brothers, sisters or children) suffered from any of the following. or died before the age of 65? Please specify the disease and their relationship to you.  Diabetes?  Heart Attack (under 55)?  Stroke?  Asthma?  Cancer ? |
| Do you currently suffer from any of the following? Please specify details below:  Diabetes?  Heart Attack (under 55)?  Stroke?  Asthma?  Cancer ?  Learning Difficulties? |
| Please give details of any serious illnesses you have suffered including dates: |

|  |
| --- |
| ****COMMUNICATING WITH YOU**** - it is very important that we can communicate well with our patients.  We want to make sure you can read and understand the information we send you.  If you find it hard to read letters or if you need someone to support you at appointments, please let us know. We want to know if you need information in braille, large print or easy read.  We want to know if you need a British Sign Language interpreter or advocate. We want to know if we can support you to lip read or use a hearing aid or communication tool.  DO YOU HAVE ANY SPECIAL INFORMATION OR COMMUNICATION NEEDS? YES / NO  (Please circle your answer) |
| If you answered Yes to the above question please tell us what your particular needs are: |



ALCOHOL QUESTIONNAIRE DATE:

PLEASE CIRCLE YOUR ANSWER TO EACH QUESTION



ETHNIC CATEGORY AND FIRST LANGUAGE QUESTIONNAIRE

As part of our registration process all new patients are asked to complete this questionnaire.

*This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.*

ETHNIC CATEGORY

Please indicate your ethnic category. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

This form may only be completed by the patient in person, or a parent in the case of a child. It may not be changed by us unless you ask for a change. This information will be added to your computer health record and will remain confidential.

Choose ONE section from A to F, and then tick ONE box to indicate your background. If asked to specify, please do so as fully as possible. If you do not wish to enter your ethnic category please go straight to section F.

A White

|  |  |
| --- | --- |
|  | British |
|  | Irish |
|  | Any other white background please write in below |

|  |
| --- |
|  |

B Mixed

|  |  |
| --- | --- |
|  | White and Black Caribbean |
|  | White and Black African |
|  | White and Asian |
|  | Any other mixed background please write below |

|  |
| --- |
|  |

C Asian or Asian British

|  |  |
| --- | --- |
|  | Indian |
|  | Pakistani |
|  | Bangladeshi |
|  | Any other Asian background please write below |

|  |
| --- |
|  |

D Black or Black British

|  |  |
| --- | --- |
|  | Caribbean |
|  | African |
|  | White and Asian |
|  | Any other black background please write below |

|  |
| --- |
|  |

E Chinese or other ethnic group

|  |  |
| --- | --- |
|  | Chinese |
|  | Any other please write below |

F Not Stated

|  |  |
| --- | --- |
|  | **If you do not wish to state your ethnic origin please place a √ in the box below.** |
|  |  |

FIRST LANGUAGE MONITORING

Please indicate which is your first language by placing a tick in the relevant box below:

|  |  |
| --- | --- |
|  | Tick Here |
| 012 English |  |
| 001 Akan (Ashanti) |  |
| 002 Albanian |  |
| 003 Amharic |  |
| 004 Arabic |  |
| 005 Bengali & Sylheti |  |
| 006 Brawa & Somali |  |
| 007 British Signing Language |  |
| 008 Cantonese |  |
| 009 Cantonese & Vietnamese |  |
| 010 Creole |  |
| 011 Dutch |  |
| 013 Ethiopian |  |
| 014 Farsi (Persian) |  |
| 015 Finnish |  |
| 016 Flemish |  |
| 017 French |  |
| 018 French creole |  |
| 019 Gaelic |  |
| 020 German |  |
| 021 Greek |  |
| 022 Gujarati |  |
| 023 Hakka |  |
| 024 Hausa |  |
| 025 Hebrew |  |
| 026 Hindi |  |
| 027 Igbo (Ibo) |  |
| 028 Italian |  |
| 029 Japanese |  |

|  |  |
| --- | --- |
|  | Tick Here |
| 030 Korean |  |
| 031 Kurdish |  |
| 032 Lingala |  |
| 033 Luganda |  |
| 034 Makaton (sign language) |  |
| 035 Malayalam |  |
| 036 Mandarin |  |
| 037 Norwegian |  |
| 038 Pashto (Pushtoo) |  |
| 039 Patois |  |
| 040 Polish |  |
| 041 Portuguese |  |
| 042 Punjabi |  |
| 043 Russian |  |
| 044 Serbian/Croatian |  |
| 045 Sinhala |  |
| 046 Somali |  |
| 048 Spanish |  |
| 049 Swahili |  |
| 050 Swedish |  |
| 051 Sylheti |  |
| 052 Tagalog (Filipino) |  |
| 053 Tamil |  |
| 054 Thai |  |
| 055 Tigrinya |  |
| 056 Turkish |  |
| 057 Urdu |  |
| 058 Vietnamese |  |
| 059 Welsh |  |
| 060 Yoruba |  |
| 200 Other |  |

ARE YOU A CARER?

*A carer is someone, who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability.*

YES / NO (Please circle as appropriate)

Please provide the following details for the person you care for:

Name:

Date of Birth:

Your relationship to this person:

Please note if you answer yes to this question you will be added to the Practice Carers Register. We have a dedicated Carers Lead in the practice who can offer advice and support. Please ask at reception.

*THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE*

YOUR FULL NAME: ………………………………………………………….……….. DATE OF BIRTH:…………..…………

(Please use capital letters)

Your signature:…………………………….. ………………………

*Date Form Completed*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| SCR-logo.png |  | logo.jpg |
|  |
|  |
|  |
|  |
|  |

Dear Patient

**Summary Care Record – your emergency care summary**

One of the ways of sharing your health information for your care is through the Summary Care Record (SCR). The SCR is available nationally to health professionals who may care for you. It contains important information about any medicines you are taking, any allergies you suffer from, and any bad reactions to medicines that you have had. Access to this information can prevent mistakes from being made when caring for you in an emergency, or when your GP practice is closed.

You can also ask for your SCR to include additional information about you, such as your current health conditions. This is known as an Enriched SCR.

We will only add information to your SCR with your consent; please complete the questions on the registration form to let us know whether or not you would like a SCR.

Further information on the SCR can be viewed at: <https://www.digital.nhs.uk/summary-care-records>.

Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Yours sincerely

Keeley Bruce

Practice Manager