

# 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

<b>1</b>	<b>Full Name:</b>			<b>Date of Birth:</b>		
	<b>Title :</b> <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms			<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other. <i>Please state :</i>		
	<b>Other. <i>Please state :</i></b>			<b>Marital Status:</b>		
	<b>Mobile tel. number:</b>  Text messaging service enables your GP Practice to get in touch with you by sending text messages to your mobile phone (e.g. text appointment reminders).  IF YOU CHANGE YOUR MOBILE NUMBER, PLEASE LET YOUR GP KNOW AS SOON AS POSSIBLE.  If you don't want to receive text messages from your practice tick here: <input type="checkbox"/>			<b>Maiden name / Mothers name if different:</b>		
	<b>Work tel. number:</b>			<b>E-mail address:</b> If you don't want to receive emails to this address from the practice please tick here: <input type="checkbox"/>		
	<b>Next of Kin:</b> <b>Relationship to Patient:</b>			<b>Next of Kin contact tel. number:</b>		
	<b>Please indicate your first choice of contact method:</b> <input type="checkbox"/> Letter <input type="checkbox"/> Email <input type="checkbox"/> SMS (text) <input type="checkbox"/> Phone					
	<b>Town* and Country of birth</b> (*If town is London please state which Borough)		<b>Country:</b> <b>Town:</b>		<b>Borough (*If born in London):</b>	
	<b>If you are from abroad, date you first came to live in the UK:</b>					
	<b>Please state any country (outside UK) that you have visited/lived in for more than 6 months during the past 5 years:</b>					
	<b>Country:</b>			<b>Dates/Year (If known):</b>		
	<b>Please list other relatives of your home who are registered with us:</b>					
	<b>Relationship:</b>		<b>Name:</b>		<b>Date of Birth:</b>	

<b>2</b>	<b>Looking After Someone</b>	
	<b>Are you looking after someone?</b>	
	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.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>Is someone looking after you?</b>	
	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		
<b>Carer's name :</b>		<b>Relationship to you:</b>
<b>Address of carer :</b>		
<b>Telephone number of carer :</b>		

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

<b>4</b>	<b>Your Religion</b> (Please tick) (*PS=please state)	<input type="checkbox"/> C of E	<input type="checkbox"/> Catholic	<input type="checkbox"/> Other Christian *PS_____	<input type="checkbox"/> Bhuddist	<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 *PS_____		
	<b>Your Ethnic Origin</b> (Please tick one)	<input type="checkbox"/> White (UK)		<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 <input type="checkbox"/> 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			
	<b>What is your main spoken language?</b>				<b>Do you need an Interpreter?</b>			
	Do you speak English? Yes <input type="checkbox"/> No <input type="checkbox"/>				Yes <input type="checkbox"/> No <input type="checkbox"/>			
	<b>Do you need help with mobility/hearing/speaking?</b> (tick all that apply)							
	<input type="checkbox"/> 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 *PS_____				
	<b>Are you currently?</b>	Homeless <input type="checkbox"/>		A Refugee <input type="checkbox"/>		An Asylum Seeker <input type="checkbox"/>		
	<b>Are you housebound?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Comments:				

5	<b>Diet and Exercise</b>		<b>What type of diet do you have?</b>	
	<b>How much exercise do you do?</b>		<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	
<b>Please enter your height in</b>		<b>Please enter your weight in</b>		
Feet / inches:		cm:	Kilos/grams:	Stones / lbs:

6	<b>Lifestyle</b>			
	Are you currently a smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No		If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a day?	
	Have you ever been a smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	If you are a smoker and want to STOP please tick here: <input type="checkbox"/>			
	<b>Alcohol</b>	How much alcohol do you drink in a week? 1 unit = 1 small glass of wine, a single measure of spirits or ½ a pint beer		
<b>Units</b>				

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

8	<b>Sharing Your Medical Record</b>	
	<b>Medical Record Sharing:</b>	
	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.	
	<b>If you do want to share your GP record tick here:</b> <input type="checkbox"/> <b>If you do not want to share your GP record tick here:</b> <input type="checkbox"/>	
<b>Summary Care Record:</b>		
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.		
<b>If you do want to have a Summary Care Record created tick here:</b> <input type="checkbox"/> <b>If you do not want to have a Summary Care Record tick here:</b> <input type="checkbox"/>		

<b>9 Your Medical Background</b>				
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"/> <b>Diabetes</b> Who:	<input type="checkbox"/> <b>Asthma</b> Who:	<input type="checkbox"/> <b>Thyroid disorder</b> Who:	<input type="checkbox"/> <b>Stroke</b> Who:	<input type="checkbox"/> <b>COPD</b> Who:
<input type="checkbox"/> <b>Heart Attack</b> under age of 60 Who:	<input type="checkbox"/> <b>Cancer</b> (Specify type) Who:	<input type="checkbox"/> <b>High Blood pressure</b> Who:	Any other important family illness. Please state:	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		<b><i>If no</i></b> 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 not already mentioned:				

<b>10 Patient Participation Group (PPG)</b>	
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.	
<b>Yes</b> I am interested in becoming involved in the PPG <input type="checkbox"/>	<b>No</b> I am not interested in becoming involved in the PPG <input type="checkbox"/>

<b>11 Online Services</b>	
You can now do the following online or via the SystemOnline app: <ul style="list-style-type: none"> <li>Book and cancel appointments, order repeat prescriptions, view your Detailed Medical Record.</li> </ul> <b>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.</b>	
<b>Yes</b> I'd like to register for online services <input type="checkbox"/>	<b>No</b> I don't want to register for online services <input type="checkbox"/>
<b>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:</b>	

<b>12</b>	<b>Other Information</b>		
	Do you have a " <b>Living Will</b> " or "Advanced Directive"? (A statement explaining what medical treatment you would not want in the future)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If "Yes", can you please bring a written copy of it to your first appointment?</i>
	Have you nominated someone to speak on your behalf ( <i>e.g. a person who has Lasting Power of Attorney</i> )? <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If "Yes", please state</i> their Name: Address: Phone number:	

<b>13</b>	<b>NHS (Charges to Overseas Visitors) Regulations 2015 Self Declaration</b>
	I am a British resident and entitled to full NHS care <input type="checkbox"/> I hold a non-UK issued European Health Insurance Card (EHIC) <input type="checkbox"/> I hold an S1 form (entitlement to health care in another European Economic Area country for a limited duration) <input type="checkbox"/> For more information on your entitlement to NHS care and charges which may be applicable, please talk to your practice for a leaflet explaining the rules and entitlements for overseas patients accessing the NHS in England.

<b>14</b>	<b>NHS Health Check for patients aged 40-74 years old ("Health M.O.T")</b>
	The NHS Health Check is a health check-up for adults in England aged 40-74. It is designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. As we get older, we have a higher risk of developing one of these conditions. An NHS Health Check helps find ways to lower this risk. If you are in the 40-74 age group without a pre-existing condition and you have not had a free NHS Health Check for the past five years you are eligible for an appointment. <b>Please tick if you would like the surgery to contact you for a free NHS Health Check appointment</b> <input type="checkbox"/>

<b>CHECKLIST</b>	
Thank you for completing this form. Please check you have completed all sections where possible. Please ensure that you bring the following with you to the surgery to complete your registration:	
<b>1. Completed &amp; Signed New Patient Registration Questionnaire (this form!)</b>	<input type="checkbox"/>
<b>2. Completed &amp; Signed GMS1 Form</b>	<input type="checkbox"/>
<b>3. Photo Proof of ID</b> - e.g. Passport, Photo Driving License or Photo ID card	<input type="checkbox"/>
<b>4. Proof of Address – <i>Must be in your name and dated within the past 3 months</i></b> – <i>Provided in one of the following:</i> Bank statement, Utility Bill (Gas, Electricity, Water), Council Tax, Tenancy Agreement or Landline Phone Bill (Mobile phone bills are not accepted)	<input type="checkbox"/>
<b>5. If possible, your Immunisation Records</b> – usually the Personal Child Health Record ("Red Book")	<input type="checkbox"/>
<b>6. If possible, your NHS Card</b> – usually shows your previous GP and your NHS Number	<input type="checkbox"/>
<b>7. If relevant, your Repeat Medication Request Slip</b> from your previous GP	<input type="checkbox"/>

- 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

<b>13</b>	<b>Signature</b>	<b>Date:</b>
	Patient signature:	Signature if signing on behalf of patient:

<b>OFFICE USE ONLY</b>	Registration checked <b>Staff Signature :</b>			Need Appt? <input type="checkbox"/> Yes <input type="checkbox"/> No
Photo ID	<input type="checkbox"/> Passport	<input type="checkbox"/> Driving licence	<input type="checkbox"/> Identity card	<input type="checkbox"/> Other
Proof of Address	<input type="checkbox"/> Utility Bill	<input type="checkbox"/> Tenancy Agreement	<input type="checkbox"/> Bank Statement	<input type="checkbox"/> Other
Nominated GP	<input type="checkbox"/> Patient advised		<input type="checkbox"/> Patient not advised (add reminder to record)	