

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	
		Email address	
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:
Family Registered With Us			

* 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				
Previous GP	Name:		Address:	
Country of Birth				
Ethnicity	<input type="checkbox"/> White (UK) <input type="checkbox"/> White (Irish) <input type="checkbox"/> White (Other)	<input type="checkbox"/> Black Caribbean <input type="checkbox"/> Black African <input type="checkbox"/> Black Other	<input type="checkbox"/> Bangladeshi <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani	<input type="checkbox"/> Chinese <input type="checkbox"/> Other
Religion	<input type="checkbox"/> C of E <input type="checkbox"/> Catholic <input type="checkbox"/> Other Christian	<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:
Housing	<input type="checkbox"/> Own Home <input type="checkbox"/> Sheltered House	<input type="checkbox"/> Residential Home <input type="checkbox"/> Nursing Home	<input type="checkbox"/> Housebound <input type="checkbox"/> Homeless	<input type="checkbox"/> Refugee <input type="checkbox"/> Asylum Seeker
Employment	<input type="checkbox"/> Employed <input type="checkbox"/> Self-employed	<input type="checkbox"/> Student <input type="checkbox"/> Unemployed	<input type="checkbox"/> House husband <input type="checkbox"/> House wife	<input type="checkbox"/> Carer <input type="checkbox"/> Retired
Overseas Visitor	<input type="checkbox"/> Yes	<input type="checkbox"/> European Health Insurance Card Held (please bring details with you)		
Armed Forces	<input type="checkbox"/> Military Veteran	<input type="checkbox"/> Family member		

Communication Needs	
Language	What is your main spoken language? Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
Communication	Do you have any communication needs? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes please specify below) <input type="checkbox"/> Hearing aid <input type="checkbox"/> Large print <input type="checkbox"/> British Sign Language <input type="checkbox"/> Lip reading <input type="checkbox"/> Braille <input type="checkbox"/> Makaton Sign Language <input type="checkbox"/> Guide dog

Carer Details			
Are you a carer?	<input type="checkbox"/> Yes – Informal / Unpaid Carer <input type="checkbox"/> Yes – Occupational / Paid Carer <input type="checkbox"/> No		
Do you have a carer?	<input type="checkbox"/> Yes	Name*:	Tel: Relationship:

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

2. Medical History

Medical History

Have you suffered from any of the following conditions?

- | | | | |
|-----------------------------------|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Underactive Thyroid |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> 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

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Asthma..... | <input type="checkbox"/> Heart Disease..... | <input type="checkbox"/> Diabetes..... | <input type="checkbox"/> Depression..... |
| <input type="checkbox"/> COPD..... | <input type="checkbox"/> Stroke..... | <input type="checkbox"/> Kidney Disease..... | <input type="checkbox"/> Thyroid..... |
| <input type="checkbox"/> Epilepsy..... | <input type="checkbox"/> Blood Pressure..... | <input type="checkbox"/> Liver Disease..... | <input type="checkbox"/> Cancer..... |

Other:

No smokers in the household

Allergies

Please record any allergies or sensitivities below

None

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

None

None

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:						

One unit is:



Half a pint of regular beer, lager or cider



A small glass of wine



A single measure of spirits



A small glass of sherry



A single measure of aperitifs

Each of these is more than one unit:



A pint of 3.5% beer, lager or cider



A pint of 5% beer, lager or cider



A 330ml bottle or can of 4.5% alcopop or lager



A 500ml can of 4% lager or strong beer



A 500ml can of 8% lager



A medium (175ml) glass of 11% wine



A bottle of 12% wine

3. Your Lifestyle - Continued

Smoking

Do you smoke?	<input type="checkbox"/> Never smoked	<input type="checkbox"/> Ex-smoker	<input type="checkbox"/> Yes
Do you use an e-Cigarette?	<input type="checkbox"/> No	<input type="checkbox"/> Ex-User	<input type="checkbox"/> Yes
How many cigarettes did/do you smoke a day?	<input type="checkbox"/> Less than one	<input type="checkbox"/> 1-9	<input type="checkbox"/> 10-19 <input type="checkbox"/> 20-39 <input type="checkbox"/> 40+
Would you like help to quit smoking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

For further information, please see: www.nhs.uk/smokefree

Height & Weight

Height		Weight	
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Women Only

Do you use any contraception?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If needed, please book appointment.
Are you currently pregnant or think you may be?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Expected due date:

Students Only

Students are at risk of certain infections including mumps, meningitis and sexually transmitted infections, as well as mental health issues including stress, anxiety and depression. Please see www.nhs.uk/Livewell/Studenthealth			
I am less than 24 years old and have had two doses of the MMR Vaccination	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
I am less than 25 years old and have had a Meningitis C Vaccination	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

4. Further Details

Named Accountable GP

The GP who has overall responsibility for your care is?

You are however entitled to make an appointment to see any GP of your choice, subject to availability.

Electronic Prescribing

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

Pharmacy:

Patient Participation Group

Would you like to be involved in our Patient Participation Group? ☐ Yes ☐ No

We are committed to improving the services we provide. The Patient Participation Group is a mechanism for us to gain valuable feedback from our patients about their experiences, views and ideas for improving our services.

Blood and Organ Donation

Blood Donation

- ☐ I am already a blood donor
☐ I wish to be a blood donor
☐ I do not wish to be a blood donor

Organ Donation

- ☐ I am already registered as a donor
☐ I wish to be a donor – all body part
☐ I wish to be a donor – for these body parts:
☐ I do not wish to be a donor

To register: Online: www.blood.co.uk/the-donation-process/recognising-donors

Telephone: 0300 123 23 23 to speak to an advisor who will send out a donor card.

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

Checklist

Please ensure the following are done and provided so that your registration can be completed successfully

- ☐ Completed & Signed Above Form
☐ Completed & Signed GMS1 Form
☐ Photo Proof of ID e.g. *Passport, Photo Driving License or Photo ID card*
☐ Proof of Address e.g. *Bank statement, Utility Bill or Council Tax from within the last 3 months*

Practice Use Only

Appointment	<input type="checkbox"/> Required	<input type="checkbox"/> Not Required		
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"/> Council Tax	<input type="checkbox"/> Bank Statement	<input type="checkbox"/> Other



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?

Church Langley Medical Practice 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, please see: www.nhs.uk/NHSEngland/thenhs/records

The NHS App

Church Langley Medical Practice is inviting you to use the NHS App, a simple and secure way to access a range of NHS services on your smartphone or tablet. This a convenient way to access medical service.

You can use the NHS App to



book and cancel appointments

book, view and cancel appointments at your GP surgery



view your record

access your GP medical record securely



order repeat prescriptions

see your available medicines and place an order



check your symptoms

find trusted NHS information on hundreds of conditions and treatments and get instant advice



register your organ donation decision

choose to donate some or all of your organs and check your registered decision



find out how the NHS uses your data

choose if data from your health records can be shared for research and planning

To use the NHS App you must be a patient at our practice and have an Apple or Android smartphone or tablet.

For more information or to download the app go to www.nhs.uk/nhsapp

or use the following QR code

