**New Patient Registration Form - Adult**

Please complete all pages in full using **block capitals** and **black ink**.

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| **1. Background Details** | |
| **Contact Details** | |
| Title | Mr / Mrs / Ms / Miss / Mx / Dr / Other\_\_\_\_\_\_\_\_\_\_\_\_ |
| First Name |  |
| Middle Name(s) |  |
| Surname |  |
| Known As |  |
| Date of Birth |  |
| Gender |  |
| Marital Status | Single / Married / Common Law Partnership / Cohabiting / Widowed |
| Address | Postcode |
| Mobile Telephone | I consent to be contacted by SMS on this number: Y / N |
| Home Telephone |  |
| Work Telephone |  |
| Email |  |
| Preferred Contact Method  (circle only one option) | Letter / Email / SMS |

*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, health campaigns or Patient Participation Group details*

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| **Other Details** | | | | |
| Ethnicity | White (UK)  White (Irish)  White (Other) | Black Caribbean  Black African  Black Other | Bangladeshi  Indian  Pakistani | Arabic  Chinese  Other |
| Religion | C of E  Catholic  Other Christian | Buddhist  Hindu  Muslim | Sikh  Jewish  Jehovah’s Witness | No religion  Other: |
| Employment | Employed  Student | Self-employed  Unemployed | House husband  House wife | Carer  Retired |
| International Student | |  |  |
| Armed Forces | Military Veteran | Family member |  |  |
| Next of Kin | Name:  Contact Number:  Relationship: |  |  |  |
| Please list all members of your household (name, date of birth and relationship) | Name: DOB: Relationship:  Name: DOB: Relationship:    Name: DOB: Relationship:  Name: DOB: Relationship:  Name: DOB: Relationship:  Name: DOB: Relationship: | | | |

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| **Communication Needs** | | | |
| Language | What is your main spoken language if not English? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you need an interpreter?  Yes  No | | |
| Communication | Do you have any communication needs?  Yes  No  (If **Yes** please specify below) | | |
| Hearing aid  Lip reading | Large print  Braille | British Sign Language  Makaton Sign Language  Guide dog |

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| **Carer Details** | | | | | |
| Are you a carer? | Yes – Informal / Unpaid Carer | | Yes – Occupational / Paid Carer | | No |
| Do you have a carer? | Yes | Name\*:    Tel:  Relationship: |  |  | |

*\* Only add carer’s details if they give their consent to have these details stored on your medical record, please also indicate if they are registered with us*

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| **2. Medical History** |

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| **Medical History** | | | |
| Have you suffered from any of the following conditions? | | | |
| Asthma  COPD  Epilepsy | Heart Disease  Heart Failure  High Blood Pressure | Diabetes  Kidney Disease  Stroke | Depression  Underactive Thyroid  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: | | | |

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| **Family History** | | | |
| Please record any significant family history of close blood relatives with medical problems and confirm which relative e.g. mother, father, brother, sister, grandparent | | | |
| Stroke………………… | Asthma………….…….. | Cancer………..… | Diabetes……………….. |
| Other……………………………………………………………………………………………………………. | | | |

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| **Allergies** |
| Please record any allergies or sensitivities |

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| **Current Medication** |
| Please provide details of your current medication (name and dose). A medication review appointment is needed before repeat medication can be issued, please ask at reception. |

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| **Medication Charges** |
| If you are prescribed medication(s), please indicate below how we are to charge you.  Do you pay on collection, prepay or have an exemption? |
| Payment on collection  A. 60 years of age or over or under 16 years of age (unless your date of birth is printed on the form)  B. is 16, 17, or 18 and in full time education  D. Maternity exemption certificate  E. Medical exemption certificate  F. Prescription prepayment certificate  G. Prescription exemption certificate issued by Ministry of Defence  L. HC2 (full help) certificate  H. Income Support or Income-related Employment and Support Allowance  K. Income-based Jobseeker’s Allowance  M. Tax Credit exemption certificate  S. Pension Credit Guarantee Credit (including partners)  U. Universal Credit and meets the criteria*. Find out more at* [www.nhsbsa.nhs.uk/UC](http://www.nhsbsa.nhs.uk/UC) |

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| **3. Your Lifestyle** |

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| **Alcohol** | | | | | | | |
| Please answer the following questions which are validated as screening tools for alcohol use: | | | | | | | |
|  | **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 |  | |
| A score of **less than 5** indicates *lower risk drinking* | | | | | | TOTAL: |  | |
| **Scores of 5 or more** requires the following 7 questions to be completed | **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: |  | |

[](http://www.citsu.ie/alcohol-and-drug-awareness)

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| **3. Your Lifestyle - Continued** |

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| **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](http://www.nhs.uk/smokefree) | | |

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| **Height & Weight** | |
| Height (cm) |  |
| Weight (kg) |  |

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| **Activity** Please tick one box that is closest to your present work activity from the following five possibilities | |
| I am not in employment (e.g. retired, retired for health reasons, unemployed, full-time carer etc.) |  |
| I spend most of my time at work sitting (such as in an office) |  |
| I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.) |  |
| My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.) |  |
| My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.) |  |
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| **During the *last week* how many hours did you spend on each of the following activities?**  **Please mark only one box on each row** |

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|  | None | Some but less than 1 hour | 1hr-3hrs | 3hrs or more |
| Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc. |  |  |  |  |
| Cycling, including cycling to work and during leisure time |  |  |  |  |
| Walking, including walking to work, shopping, for pleasure etc. |  |  |  |  |
| Housework/Childcare |  |  |  |  |
| Gardening/DIY |  |  |  |  |

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| **How would you describe your usual walking pace? Please mark one box only** | | | |
| Slow pace (less than 3 mph) |  | Steady average pace |  |
| Brisk pace |  | Fast pace (over 4 mph) |  |

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| **Women Only** | |
| Do you use any contraception? | Yes  No If needed, please book appointment. |
| Are you currently pregnant or think you may be?  Are you overdue a cervical screening test? | Yes  No Expected due date:  Yes  No If needed, please book appointment. |

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| **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](http://www.nhs.uk/Livewell/Studenthealth) | | | |
| I am less than 24 years old and have had two doses of the MMR Vaccination | Yes | No | Unsure |
| I am less than 25 years old and have had a Meningitis C Vaccination | Yes | No | Unsure |

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| **4. Sharing Your Health Record (see following sheet for further information)** |

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| **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  Do you consent to your GP Practice viewing your health record from other organisations that care for you?  Yes *(recommended option)*  No |

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| **Your Summary Care Record (SCR)** |
| Do you consent to having an Enhanced Summary Care Record with Additional Information?  Yes *(recommended option)*  No |

**The above is separate from the General Practice Data for Planning & Research (GDPR) data extraction due 01/09/21. For further details please see our website.**

**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?**

Bottisham 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 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](http://www.nhs.uk/your-nhs-data-matters)

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| **5. Signature and Checklist** |

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| **Signature** | |
| 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**

For your registration to be completed successfully please ensure you have:

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|  | Completed & Signed New Patient Registration Form |
|  | Completed & Signed GMS1 Form  Please provide the following, |
|  | 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 (online versions accepted)* |

If ID and Proof of address are not provided we may only be able to register you as a temporary patient or we may require to see evidence at a later date.

**Practice Use Only**

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| --- | --- | --- | --- |
| Photo ID | Passport  Driving licence  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  All Names match form?  Yes No (check reason why- is other ID required such as marriage certificate)  DOB on ID and forms match  Yes No | | |
| Proof of Address | Utility Bill  Council Tax  Bank statement  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Carer Form? | Required  Not Required | |  |
| Preferred Contact Method Selected | Yes | No (if no ask Pt to confirm) | |
| GMS1 Completed including | NHS Number  Place of Birth  Previous Address  Previous GP | | |
| If from Abroad | Date first came to UK completed in full including day / month / year | |  |
| If Military Veteran | Dates of enlistment/discharge are completed in full including day / month / year | | |
| Form Taken in by | Initials Date | |  |