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

Please fully complete this questionnaire as missing information can result in a delay of your registration

1	**Full Name:**				**Date of Birth:**
	Title : ☐ **Mr**	☐ **Mrs**	☐ **Miss**	☐ **Ms**	**Gender:** ☐ **Male** ☐ **Female** ☐ **Other.** *Please state* **:**
	Other. *Please state* **:**				**Marital Status:**
	Mobile tel. number: We will use this to send appointment reminders and health promotion details. Please tick here to give your consent for this: ☐				**Maiden name / Mothers name if different:** **Current Address:**
	Work tel. number:				**E-mail address:**
	Next of Kin: **Relationship to Patient:**				**Next of Kin contact tel. number:**
	Please indicate your first choice of contact method: ☐ **Letter** ☐ **Email** ☐ **SMS (text)** ☐ **Phone**				
	Town* and Country of birth **(*If town is London please state which Borough)**	**Country:** **Town:**			**Borough (*If born in London):**
	Please list other relatives of your home who are registered with us:				
	Relationship:	**Name:**			**Date of Birth:**

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 :	

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*:**			

4							
	Your Religion (Please tick) (*PS=please state)	☐ C of E	☐ Catholic	☐ Other Christian *PS_ _ _ _ _ _ _ _ _	☐ Bhuddist	☐ Hindu	☐ Muslim
		☐ Sikh	☐ Jewish	☐ Jehovah's Witness	☐ No religion	☐ Other religion *PS_ _ _ _ _ _ _ _ _ _ _	
	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 ☐			
	Do you need help with mobility/hearing/speaking? (tick all that apply)						
	☐ Wheelchair	☐ Walking aid	☐ Hearing aid	☐ British sign language (BSL)	☐ Makaton sign language		
	☐ Lip reading	☐ Large print	☐ Braille	☐ Other *PS _			
	Are you currently?	Homeless ☐	A Refugee ☐	An Asylum Seeker ☐			
	Are you housebound?	Yes ☐ No ☐	Comments:				
	If returning from the Armed Forces please state which below: **Comments:** ☐ **Army** ☐ **Royal Navy** ☐ **Royal Air force**						

Please state any country (outside UK) that you have visited/lived in for more than 6 months during the past 5 years	
Country:	**Dates/Year (If known):**

5	**Diet and Exercise**		**What type of diet do you have?**	
	How much exercise do you do?		☐ Healthy	
	☐ Sedentary (No exercise)		☐ Unhealthy	
	☐ Gentle (climbs stairs, walking , gardening)		☐ Vegan	
	☐ Moderate (Cycling, swimming regularly)		☐ Vegetarian	
	☐ Vigorous (Attends gym regularly)		☐ Moderate	
	Please enter your height in		**Please enter your weight in**	
	Feet / inches:	**cm:**	**Kilos/grams:**	**Stones / lbs:**

6	**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.		

This is **one unit**...

Half pint of regular beer, lager or cider

One very small glass of wine

One single measure of spirits

One small glass of sherry

One single measure of aperitifs

...and each of these is **more than one unit**...

2 A pint of regular beer, lager or cider

3 A pint of premium beer, lager or cider

1.5 Alcopop or a can/bottle of regular lager

2 440ml can of premium lager or strong beer

4 440ml can of super strength lager

2 175mm glass of wine

9 Bottle of wine

Please have a look at the above diagram and then answer the questions on the next page.

Total AUDIT Score (Questions 1 – 10):

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	
2. 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+	
3. 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						
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	
5. 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	
6. 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	
7. 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	
8. 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	
9. 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	
10. 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	

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

7	**Women Only**	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

8	**Your Medical Background**				
	Are there any serious diseases that affect your parents, brothers or sisters? Tick all that apply ***and*** state family member:				
	☐ **Diabetes** Who:	☐ **Asthma** Who:	☐ **Thyroid disorder** Who:	☐ **Stroke** Who:	☐ **COPD** Who:
	☐ **Heart Attack** under age of 60 Who:	☐ **Cancer** (Specify type) Who:	☐ **High Blood pressure** Who:	Any other important family illness. Please state: (angina,epilepsy, dvt, etc)	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?	☐ Yes ☐ No	***If no*** 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: **If you do not complete this section and you are on repeat medication, there might be a delay in us being able to issue your next repeat prescription.**				
	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:				

9 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.

If you don't want to share your GP record tick here: ☐

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.

If you don't want to have a Summary Care Record tick here: ☐

10 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 ☐

11 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 ☐

12 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:	

CHECKLIST

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:

1. **Completed & Signed New Patient Registration Questionnaire** (this form!) ☐
2. **Completed & Signed GMS1 Form** ☐
3. **Photo Proof of ID** - e.g. Passport, Photo Driving License or Photo ID card ☐
4. **Proof of Address** – ***Must be in your name and dated within the past 3 months*** ☐
   – *Provided in one of the following:* Bank statement, Utility Bill (Gas, Electricity, Water), Council Tax, Tenancy Agreement or Landline Phone Bill (Mobile phone bills are not accepted)
5. If possible, your **Immunisation Records** – usually the Personal Child Health Record ("Red Book") ☐
6. If possible, your **NHS Card** – usually shows your previous GP and your NHS Number ☐
7. If relevant, your **Repeat Medication Request Slip** from your previous GP ☐

- **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**

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

OFFICE USE ONLY	Need Appt? ☐ Yes ☐ No Need Etoh Advice? ☐ Yes ☐ No			**Staff Initials:**
Photo ID	☐ Passport	☐ Driving licence	☐ Identity card	☐ Other
Proof of Address	☐ Utility Bill	☐ Tenancy Agreement	☐ Bank Statement	☐ Other
Nominated GP	☐ Patient advised		☐ Patient not advised (add reminder to record)	